Applying a social model of disability across the life span

Shanna K. Kattari, Angela Lavery & Leslie Hasche

Routledge
Taylor & Francis Group

Check for updates

Applying a social model of disability across the life span

Shanna K. Kattari[a], Angela Lavery[b], and Leslie Hasche[c]

[a]School of Social Work, University of Michigan, Ann Arbor, Michigan, USA; [b]College of Education and Social Work, West Chester University, West Chester, Pennsylvania, USA; [c]Graduate School of Social Work, University of Denver, Denver, Colorado, USA

ABSTRACT

With an estimated 21.3% of persons aged 15 and older experiencing disability in the USA, social workers will see clients present with disabilities across all practice settings and stages of human development. Yet, the training and terminology of social workers—which often closely aligns with medical professionals—may seem to occur in isolating silos or disciplinary theories. Social work education often views the needs of older adults and people with disabilities as two distinct populations, despite the fact that many of these individuals share similar needs for access, resources, and support. Furthermore, when discussing human development, the focus may skew to individual affective, behavioral, and cognitive processes and indicators of abnormal development and frailty. Thus, by clarifying terminology and applying a social model of disability across the life span, we identify how educational efforts related to human behavior and the social environment can promote intersectional and inclusive social work related to aging and disability.

Introduction

A significant portion of the individuals and populations supported by social workers fall in the category of being disabled in some way, such as with physical, intellectual, or developmental disabilities (National Association of Social Workers, 2006), with an estimated 21.3% of persons aged 15 and older experiencing a disability in the USA (United States Census Bureau, 2012). Disability, including functional impairments and cognitive impairments among older adults, is listed as a protected status in the National Association of Social Workers' Code of Ethics (NASW, 2008), and NASW notes the importance of ensuring access, support, and equity for clients with disabilities. Thus, social workers serve clients with disabilities across all age groups in social service settings involving child welfare, schools, health, mental health, and aging services. For many of these settings, the specialty training, terminology, and practice rely on foundational medical models of care with a focus on diagnosis, impairment, and individual coping—which may seem incongruent with the field of disability studies, as well as disability advocacy. Thus, with the purpose of reviewing terminology and illustrating how a social model of disability can serve as essential foundational knowledge, we propose ways to integrate this content into human behavior and the social environment courses. Such knowledge may promote the

CONTACT Shanna K. Kattari ✉ Shanna.Kattari@du.edu 🖂 School of Social Work, University of Michigan, 1080 S. University Ave, Ann Arbor, MI, 48109, USA.

inclusiveness and effectiveness of responding to disability issues across specialty service settings and age groups.

Within social work research and education broadly, disability content is often found with great variation in depth and reach, within academic courses and silos, and in separate organizations and policies (e.g., Americans with Disabilities Act, Protection and Advocacy agencies within the National Disabilities Rights Network (NDRN), the American Association for People with Disabilities, Disability Rights Education and Defense Fund, National Association of the Deaf, American Council of the Blind, National Council on Disability, American Association on Intellectual and Developmental Disabilities). As per Bean and Krcek's (2012) recent study, 80% of the top 25 social work programs in the USA had disability content in course titles or descriptions. Additionally, the number of classes offering disability content per school ranges from only one course up to 26 unique courses, indicating a huge range for how social work educational programs include disability content (Bean & Krcek, 2012).

Furthermore, the Council on Social Work Education's (CSWE) Educational Policy and Accreditation Standards (EPAS) began requiring the inclusion of disability-related content in BSW and MSW curricula in 2001, yet the 2015 EPAS mentions disability only twice as it relates to diversity (CSWE, 2015). Similarly, while advanced gerontology practice behaviors, as per CSWE Gero-Ed Center (2017) and the Association of Gerontology of Higher Education (2014), mention issues of cognitive, physical, and mental functioning and sensory limitations, the word disability minimally appears anywhere in these specified practice behaviors and competencies.

Given the likelihood that a social worker will have a disabled client at some point during their career, it is crucial that foundational social work education, such as courses on human behavior and the social environment, incorporate disability issues and terminology in order to best meet their clients' needs and fulfill their commitment to the NASW Code of Ethics. Based on the research of disability advocate, researcher and social worker, Romel Mackelprang (2010), CSWE has promoted the inclusion of disability as an additional facet of diversity and inclusion. Yet Mackelprang (2010) critiques NASW for clinging firmly to the medical model of disability and emphasizes on risks and disadvantages faced by the individual client—minimal recognition is given to the role of environment in creating the context of disability nor the presence of many social workers with disabilities effectively serving the profession. To our knowledge, little evidence exists to identify where and how within social work curriculum issues of disability across the life span are addressed. Several textbooks for human behavior and the social environment do include chapters on disability and aging (Hutchison, 2017; Lesser & Pope, 2011; Schriver, 2004), thus we propose that this content on a social model of disability may fit well within human behavior and the social environment courses.

Furthermore, these initiatives around disability in social work education often fail to connect how the concept of disability may differ across the life span. For example, intersections between aging and disability services are often found in practice, but not in our research and conceptual models (Putnam, 2007a; Putnam & Stoever, 2007). Even aging services (e.g., adult day centers, area agencies on aging, hospitals, hospices, home-care and home health agencies, institutional long-term care), which often focus on cognitive and functional impairments, may not make the explicit connections to the disability issues or models (Putnam, 2007b). Practice settings are increasingly combining

aging and disability services through community-based and institutional long-term ser-vices and supports, person-centered and participant-directed care and Aging and Disability Resource Centers (Hudson, 2014). Thus, our terminology needs to explicate how issues of age and disability overlap and are at times distinct over the life span. We propose that emphasizing the use of a social model of disability can offer this clarification and serve as a foundational knowledge competency for human behavior and the social environment courses. Given the focus of many human behavior and the social environ-ment courses on the developmental stages across the life span, the person-in-environment, and the sometimes confounding of age and disability; we assert that incorporating this terminology and the social model of disability is needed. This article offers clarifications on the definitions, language, and overview of a social model of disability, and implications for our educational approaches.

Disability terminology

Defining disability

The act of defining something should be, in thought, quite simple, it can be very difficult in practice, with many potential definitions for the same word (Leonardi, Bickenbach, Ustun, Kostanjsek, Chatterji, & MHADIE Consortium, 2006). The term disability, and how to define it, has been discussed and debated throughout the ages, included inter-nationally by the United Nations Convention on the Rights of People with Disabilities (United Nations Enable, 2006).

It is important to note that disabilities and impairments may be acquired throughout the life span, in addition to being congenital, or existing from time of birth (Smart, 2011). Some clients will age with a lifelong disability while other older individuals may acquire a variety of disabilities at any point in their life course, including old age. For example, neurocognitive disorders can encompass conditions such as dementia, intellectual/devel-opmental disabilities, traumatic brain injury and stroke—some of which may have age as an established risk factor (Centers for Disease Control and Prevention, 2011). Furthermore, disabilities such as arthritis, stroke, vision impairment, and hearing impair-ment that are commonly thought of as related to aging also exist in young and middle-aged persons (Ellis, 2010; Roos, 2005), once again creating a crossover between popula-tions served in health, mental health, aging, and disability service settings. Defining disability is complicated by the many ways it may vary across individuals and conditions, such as in terms of age of onset, severity, or intensity of the condition, and the progressive or episodic nature of the course of these conditions.

Furthermore, it is important to acknowledge how the language and definitions used for people who fit the definition of having a disability have changed over time. More recently, terms that were made popular several decades ago such as handicapped, differently able, and mentally retarded, are now considered inappropriate for use regarding people with disabilities. In the 1990s and 2000s, there was a strong push for the concept of "person first language," and the term "people with disabilities" was popularized (as were similar person first terms such as person in a wheelchair, person with autism, etc.) (Brown, 2010; Millington & Leierer, 1996). However, the language pendulum has begun to swing back, and disability activists are suggesting that since society and the environment/contexts in which a person lives are actually

more "disabling" through valuing certain abilities over others than any specific impairment might be, the term "disabled person" or "disabled people" is more appropriate (Brueggemann, 2013; Collier, 2012; Davis, 2013). These advocates also make the point that we use identity adjectives to describe others; a Black man, a lesbian woman, a lower income family, suggesting that it is odd linguistically to use a person's first language solely for disability-related identities (Mackelprang & Salsgiver, 2015).

Given that people who fit the definition of disability are divided on the language they personally want to be used, this article will use both people with disabilities and disabled people interchangeably to honor all those whose identities fall into this realm. NASW uses the language "mental or physical disability" in the Code of Ethics (NASW, 2008), an interesting decision, given that the overarching language of "mental disabilities" has since been replaced by the disability community with such terms as intellectual and developmental disabilities and/or psychosocial disorders and mental health/socio-emotional disabilities (Oaks, 2012; Schalock et al., 2010). Additionally, many disability advocates promote the use of the terms neurodiversity and neurodiverse instead of the more diagnostic language of abnormal psychology to refer to issues of autism and others with intellectual, developmental, and learning-related disabilities/impairments (Attwood, 1998; Mackenzie & Watts, 2011). This language moves away from viewing these diagnoses as problematic, and re-centers disability as simply one more facet of diversity present within humanity (Mackenzie & Watts, 2011). As a marker for those who do not experience being neurodiverse, the term neurotypical is used to avoid labeling these individuals as "normal" in comparison (Attwood, 1998).

Given all these complications, we offer this definition of disability that uses the definition of the International Classification of Functioning, Health and Disability (ICF) adopted by the World Health Organization in 2001, in conjunction with the definition adopted and used by the United Nations Enable convention in 2006, and which have been joined in tandem by Leonardi et al. (2006). This defines disability as "a difficulty in functioning at the body, person, or societal levels, in one or more life domains, as experienced by an individual with a health condition in interaction with contextual factors" (p. 1220, 2006). This definition acknowledges the variety of disabilities and impairments that fall under the term of "disability," the fact that difficulty in functioning may occur at many levels and severities, and places this within context, or the fact that different environments may have different expectations for and social constructions regarding ability, resulting in differential impact of disability on any individual. Moreover, this definition of disability, while including the term "health," does not refer to diagnoses as part of the definition, moving away from the medical model of disability, and towards the social model of disability, impairments, and ability expectations (Shakespeare, 2006; Union of the Physically Impaired Against Segregation, 1974).

> The WHO's ICF is important to include in this discussion, as it offers
> [...] a standard language and framework for the description of health and health-related states [...] .ICF is a multipurpose classification intended for a wide range of uses in different sectors. It is a classification of health and health-related domains—domains that help us to describe changes in body function and structure, what a person with a health condition can do in a standard environment (their level of capacity), as well as what they actually do in their usual environment (their level of performance). (WHO, 2002).

This definition of health, which is inclusive of disability, impairment, and differential functioning, is helpful for service professionals in re-assessing how disability can be seen as a difference that is part of human diversity, rather than something problematic that should be "fixed" or "rehabilitated." The ICF is designed to support a variety of professional issues related to disability, including but not limited to policy creation, research, and clinical interactions. On an individual level, functioning becomes more of the focus, with questions such as "what is this person's level of functioning? What treatment or interventions can maximize functioning? What are the outcomes the treatment?" (2002, p. 6), while at the institutional level, ICF suggests asking questions such as "how well do we serve our clients? How useful are the services we are providing?" (2002, p. 6). From an overall social perspective, questions might include "what are the needs of various persons with disabilities—impairments, activity limitations and participation restrictions? How can we make the social and built environment more accessible for all persons, those with and those without disabilities? Can we assess and measure improvement?" (2002, p. 6).

When conceptualizing the role of disability in a practice setting, these are some factors that may need to be considered to individualize this definition for each client:

(1) client's language preference regarding disability and narrative for the impact of the condition on one's life;
(2) client's experience of the condition across the life span: age of onset, duration and nature of course of condition, level of impairment and distress from the condition, and the societal response to the condition (i.e., barriers, stigma);
(3) social and community resources available that may be age or condition specific;
(4) client's relationship with their disability/impairment and their identity (or lack thereof) around it; some individuals embrace having a disabled identity while others may feel stigma or shame regarding this part of themselves;
(5) how members of clients' family systems regard disability and impairment;
(6) organizational and government policies regarding disability and access to support;
(7) intersectional identities of the client, including but not limited to race, sex, gender identity, sexual/romantic orientation, socioeconomic status, religion, citizenship, age, family status, etc.;
(8) geographic location (regarding both region, and setting such as urban, suburban, rural).

Social model versus medical model of disability

Much of social work education and practice approaches the concept of disability and people with disabilities from a medical model of disability (Mackelprang, 2010), given the medical dominance in many aging, health, and mental health service settings. This medical model, which arose from a moral model around disability/impairment, actively pathologizes those who are disabled and sees disability as something broken that needs to be fixed (Mackelprang & Salsgiver, 2015). Rather than recognizing all of the factors that may impact individuals with disabilities and how they interact with their environment, this medical model centers only on the disability or impairment itself, viewing the

individuals and their body/mind as the problem, while claiming to be objective and therefore unbiased (DeJong, 1979; Watson, 2012). By operating on this model, social work inherently places disability as "less than," an experience of loss when it coincides with aging, or even something to be fixed, as suggested by the use of language connecting disability and rehabilitation (such as the Journal of Social Work in Disability and Rehabilitation). Another example is the fact that NASW uses the language "social workers help people overcome some of life's most difficult challenges: poverty, discrimination, abuse, addiction, physical illness, divorce, loss, unemployment, educational problems, disability, and mental illness" (NASW, 2010). By including disability alongside poverty, addiction and other negative things as something to be overcome, this may further reinforce the medical model of disability as non-normative and problematic.

The social model of disability originally stems from a movement within the UK between the work of the Union of the Physically Impaired Against Segregation and the Disability Alliance (Oliver, 2013, 1990; Owens, 2015). This movement created awareness of disability as a social construct, and focuses on society's systemic role in oppression of those with impairments, or whose bodies/minds engaging the world outside of socially constructed expectations of ability. Michael Oliver further developed this work and proposed the social model of disability. Oliver's work (1990, 2013) asked social workers to use a critical lens when considering the individual and medical models of disability, and to start to refocus this lens on "[…] the disabling impact of society" (Oldman, 2002, p. 798).

This social model of disability (Shakespeare, 2006; Union of the Physically Impaired Against Segregation, 1974) recognizes impairment as distinguished from disability; it defines impairment as individual and private (someone who is blind, or has limited mobility), while defining disability as structural and public (society's reaction to impairment, which then "disables" individuals by how their impairments operate within an ableist society). While the medical model treats disability as an individual problem, one that should be "fixed," the social model understands disability to be a social creation, specifically the relationship between an impairment and a society that is disabling (Shakespeare, 2006).

The social model also supports non-disabled or able-bodied/neurotypical individuals being able to learn from people with disabilities, and viewing them as valuable members of society (Cameron, 2014). The social model is not suggesting that society pretend that disabled people or those with impairments do not exist. However, it posits that by acknowledging impairments as difference, and not as problems, and by creating more accessible and inclusive spaces and policies, people would be free to engage in their lives in whatever way best suited them, rather than continually having their disabled identity, or their failure to meet society's ability expectations, frame their experiences (Scheer & Groce, 1988; Wolbring, 2008, 2012a).

Disability research

Much of the extant research on disability/impairment originates from both outside the field of social work, and from outside the USA, although the last decades have birthed the disability studies field. Given the large number of people with disabilities in the USA, the arena of disability studies and policy is ripe for further development (Schriner, 1990; Scotch, 2009), particularly in comparison to the knowledge based in countries such as

Canada, the UK, and Australia. Social work should be part of this growth. Much of the research on disability within the field of social work has not occurred recently, but rather was conducted in the late 1990s and early 2000s. Gilson, Bricout, and Baskind suggest that social work is not doing enough for disabled individuals, and by placing social workers in "expert" roles, these social workers are actually disempowering their disabled clients by focusing on the "problem" of disability, rather than using a strengths-based perspective (1998). Other research suggests that social workers tend to stereotype people with disabilities, moving in the opposite direction from empowerment and self-determination (Middleton, 1998). Conversely, Beaulaurier and Taylor focus on how the social model of disability is actually in line with social work practice values, in that it focuses on empowering the client, viewing the individual as the expert on their own bodies, needs, and experiences, and supporting client self-determination by having the client participate with informed involvement in all steps of the process (2001).

While we try to ground our recommendations for the terminology and use of the social model of disability in research, the available evidence is limited. With hopes that research will continue to develop our knowledge base, the implications for teaching of human behavior and the social environment courses may still be drawn from this review of terminology and conceptual models.

Integrating disability across the life span in social work education

Common human behavior and social environment frameworks

Three core social work values and frameworks serve as natural points of integration between a social model of disability within generalist social work education: social justice, systems approach, and intersectionality. For each of these areas, we will review how disability and aging content may overlap or be distinctly highlighted.

The social justice issues of ableism, ageism, and paternalism within the developmental context

An integral value of social work, social justice's role in social work practice, and for human behavior and the social environment content, which often means attending to the importance of language and developmental contextualism (Lesser & Pope, 2011).

Disabled individuals are often labeled as vulnerable populations who experience oppression in myriad ways. Yet, the experiences of disability do not equate inherently to vulnerability—vulnerability may result more directly from the environmental context, as purported by the social model of disability. Furthermore, while increasing attention is being paid to issues of ableism (Wolbring, 2012b) and ageism (Gendron, Welleford, Inker, & White, 2015), few articles discuss the overlapping nature of these mechanisms of bias, prejudice, and discrimination. Like disability, aging is seen as a problem, a negative, depressing, and dreaded process that must be fought to prevent or be fixed. Older adults—those with and without disabilities—are often made invisible or seen as vulnerable or needy by media and US culture. Via television, internet, movies, and magazines, whether entertainment or advertisement, individuals receive strong messages about how they should dread aging or invest in anti-aging products.

Many definitions of ageism have been proposed. Robert Butler (1969) was the first to define ageism. Butler wrote ageism is "a process of systematic stereotyping and discrimination against people because they are old, just as racism and sexism accomplish this for skin color and gender" (Butler, 1969, p. 244). Wilkinson and Ferraro (2002) define ageism as "prejudice and discrimination against older people based on the belief that aging makes people less attractive, intelligent, sexual, and productive" (p. 340). Ageism and ableism have some commonalities and connections.

Campbell (2001) defines ableism as "[…] beliefs, processes and practices that produce a particular kind of self and body that is projected as the perfect, species-typical and therefore essential and fully human. Disability is cast as a diminished state of being human" (p. 44). Campbell (2008) also adds that the "[…] ableist viewpoint is a belief that impairment or disability (irrespective of 'type') is inherently negative and should the opportunity present itself, be ameliorated, cured or indeed eliminated" (p. 154). Ableism can lead to disablism (Miller, Parker, & Gillinson, 2004). Wolbring (2012b) writes, this is "the lack of accommodation for the needs of people and other biological structures seen to lack certain abilities; and the unwillingness to adapt to the needs of others" (Wolbring, 2012b, p. 295;). Ableism, disablism, and ageism are linked to paternalism.

Mary Jackman (1994) discusses how paternalism is basically one of the tools used by those in power in order to continue to dominate and maintain their current status. Jackman (1994) explains how paternalism is "the most efficient and gratifying means for the social control of relationships between unequal groups" (p. 11). Paternalism is used as a tool to execute ageism and ableism within families, communities, policy, and in agency through the administration of services and resources that older adults and those with a disability utilize. Whether it is an adult child coercing or pressuring an older adult parent to discard their belongings during relocation or it is a housing manager doing a routine inspection of an independent living apartment, paternalism is utilized to dominate and is part of the structural environment. The whole act of paternalism implies that there is a certain level of "lack of maturity or moral competence to make the 'wisest' decisions for themselves" (Jackman, 1994, p. 13). Thus, as content on human behavior and the social environment discusses development across the life span, a social model of disability would call attention to the language, the potential paternalism, ageism, and ableism in practice approaches, and the relation of all this to social work's value of social justice.

The systems approach of communities for all and universal design

Whether the focus is on the person-in-environment, ecological systems, or resilience theories, the emphasis on the goodness of fit, transactions, and adaptability of the context, environment, and place with the individual is a long-standing tenet of social work theories (Greene, 2014; Robbins, Chatterjee, & Canda, 2012).

One example of the connection of the social model of disability may be illustrated by the ecological model of aging that depicts how the physical, social, and emotional resources of older adults and their environments interact to impact functioning and ability to maintain living in the community (Lawton & Nahemow, 1973). An older adult may change or adapt their environment in order to better meet their needs so that they may *age in place* (Lawton, 1974). For example, an older adult may install grab bars in their bathroom or go to a local equipment loan program and borrow a shower chair to use in their bathtub in order to support and assist themselves while bathing. These

are only further examples of how environments that are not thoughtfully created work to disable individuals, whereas the social model of disability would support including grab bars and access devises in universal design of all spaces.

Although this framework is important in understanding and examining aging in place and aging-friendly communities, some are suggesting that we consider envisioning "communities for all" versus "aging-friendly communities" (Ball, 2012; Brown & Henkin, 2014; Morrow-Howell & Pitt-Catsouphes, 2015). For example, access to reliable transportation is helpful to community members of all ages, abilities, and incomes. Communities within the USA are not designed to address the changing demographics of the older adult population (US Department of Housing and Urban Development [HUD], 2013; Scharlach, 2012) or the ongoing issues of accessibility for persons with disabilities of all ages. The way communities have been designed separates residential living areas from commercial areas, which greatly restricts people unable to afford or operate a vehicle (Lehning, 2012). Public transportation is not accessible in many communities across the USA. (Feldman, Oberlink, Simantove, & Gursen, 2004; N4A, 2007; Scharlach, 2012). At the same time, developers of the land, the land use policies, and zoning regulations have proceeded with building communities on the assumption that everyone has access to a car that can take them to needed errands such as grocery stores and medical appointments. In addition, the majority of homes are built based on the needs of individuals who are able to scale stairs and do not utilize a wheel chair or other assistive device (Keenan, 2010; Scharlach, 2012).

A practice example that draws from this systems approach and emphasizes communities for all is advocating for universal design. Universal Design […] is "design for all people." Universal design, also known as life span design, seeks to create environments and products that are usable by children, young adults, and the elderly. They can be used by people with "normal" abilities and those with disabilities, including temporary ones (Null, 2013, p. 12).

Based on the concept of working to proactively create all spaces to be accessible to as many persons as possible, rather than providing individual accommodations to disabled people and those who have needs related to aging, Universal Design aims to make all spaces easier for all people to use from the start. There are four major tenets of Universal Design, ensuring that spaces are supportive, adaptable, accessible, and safety oriented (Null, 2013).

In social work education, teaching future social workers to design their practices and create resources that fulfill Universal Design standards creates dialogue that supports those with disabilities across the life span, rather than targeting only one population at a time. Intake forms in large print (and compatible with screen readers if online), ASL interpreters at events, captions on movies being played, mobility accessible spaces, inclusion of caregivers as part of an individual's support team, and developing skills for communicating with those who have memory loss are all mechanisms that support Universal Design principles and would allow social workers to better serve diverse clients proactively rather than reactively.

Diversity and difference through the intersectionality of age and disability

The framework of intersectionality is an important lens derived from Black critical feminist thought that can be used to better engage in understanding lived experiences of

individuals. Every individual holds multiple identities; both identities that experience marginalization in society, and identities that hold various power and privilege in society (Crenshaw, 1991; Warner & Shields, 2013). A disabled cisgender woman of color will likely have different experiences in the world than a disabled White transgender man, and the same holds true for individuals as they age; different intersections of identities will experience the world in different ways. In using an intersectional approach, social workers are better able to examine all of a client's identities and experiences, using a person in environment lens to include multiple aspects of an individual's life to best support them in planning and connecting them to resources (Kondrat, 2011). Compelling literature guided by an intersectional approach is increasingly evident for elder LGBT people of color (Van Sluytman & Torres, 2014), yet the specific inclusion of disability and aging within this work is limited.

In addition, the more intersections of marginalized identities there are with age, such as socio-economic status, race, gender, sexual/romantic orientation, and disability status, the more paternalism has intertwined with one's life and history over the years may lead to cumulative disadvantages and inclusion of a social model of disability. Social workers who engage with these populations should be prepared to support their clients in increasing access to resources and services, understanding how these marginalized identities may impact how they interact with the world, and commit to including a social justice aware lens in order to challenge injustice with precision toward issues of both ageism and ableism in their practice and the world at large.

Social model of disability and practice implications

Assessment and advocacy skills offer an important overlap between aging and disability studies, and an opportunity to link the social model of disability directly into general practice and social work education. For example, content on medical and functional assessments have long been a staple of gerontological education (McInnis-Dittrich, 2014), including terminology related to activities of daily living (ADLs, e.g., bathing, dressing, feeding), instrumental activities of daily living (IADLs, e.g., meal preparation, housework, money management), sensory impairments, and cognitive impairments. Often, an emphasis on learning medical and diagnostic terminology is advocated so that gerontological social workers can competently engage in interdisciplinary geriatric teams (CSWE Gero-Ed, n.d.). Plus, this diagnostic language based in the medical model often links directly to reimbursement for health, mental health, and aging services, thus the structural barriers exist to adopt the social model of disability.

Yet, building off of long-standing social work theories regarding the person in the environment and values, these competencies also emphasize advocacy skills. While learning medical terminology is needed, so too should be learning how to advocate and promote a social model of disability. For example, when conducting and documenting assessment information, social workers should indicate key aspects of the social experience of disability including what is disabling from the environment and context. Terminology that emphasizes 'fixing' or 'overcoming' a disability should be avoided. While individual coping may be a goal for some, so too should goals of changing the systems that are disabling. Here, social workers can take an active role in using professional confrontation skills that involve naming, confronting, and engaging with colleagues when solely medical

model terminology and goals are used. For example, social workers could describe the importance of framing deafness and being hard of hearing as an aspect of difference that involves culture and language, such as the American Sign Language. Thus, disability culture involves difference not disease. Disability culture entails defining one's identity through historical experiences, language, socialization, political activities, and subjective personal experiences, symbols, and aesthetics (Dupre, 2012). These brief encounters of advocacy and education could be opportunities for small system changes. Thus, CSWE competencies and practice behaviors can be applied to these important skills of assessment and advocacy, as well as to social workers promoting self-determination, social justice, respect for diversity, and consideration of the contextual factors.

By incorporating training on this advocacy, we are strengthening the skills of future social workers that will assist them in their work within integrative care settings and interdisciplinary teams. As we continue to address the need for interdisciplinary training and integrative care initiatives, inclusion of this advocacy skill building will empower social workers with the tools needed for promotion of those critical core values within these various cross-disciplinary settings (CSWE, 2017; Richardson & Barusch, 2006).

Additionally, workforce development initiatives highlight the need for how disability occurs across the life span. Disability, health, mental health, and aging communities face shortages of trained social workers and the overall workforce (Institute of Medicine, 2008; O'Neill, 2002). From support staff in residential facilities to individual caregivers, governmental social workers to help individuals access services to counselors and therapists helping people learn skills to successfully engage with the world, there are many roles social workers take in supporting disabled communities of all ages. There has been a call for human service paraprofessionals interested in being trained in roles similar to social workers (and perhaps using these opportunities to launch their future social work careers) to help fill these gaps (O'Neill, 2002; Rawlings, 2008). Other countries, such as Japan, recognize the need for paraprofessionals as part of the social work/social welfare field, and offer specific certifications for those individuals invested in working in long-term care (Hayashi & Kimura, 2004). UK has developed a foundation degree for this community of individuals in order to support their professional development as care professionals (Kubiak, Rogers, & Turner, 2010). In an effort to better serve disabled clients, social work should consider how our foundational curriculum around human behavior and the social environment can elevate the knowledge of social workers for themselves as well as for their role in supervising and supporting other human service paraprofessionals. Having the framework of the social model of disability, the value of social justice, the systems approach, and the attention to diversity and difference may be essential conceptual guides in this work.

Recommendations for integrating disability across the life span into human behavior and the social environment curriculum

Currently, it seems that some social work schools have disability studies certificates that are housed in multiple programs (including social work, but often also nursing, human service professions, etc.). Yet, to our knowledge, only CUNY-Staten Island's MSW program is grounded in a critical disability perspective, and specifically claims to prepare their graduates to work with people with disabilities. Given that there is a large reach for how

disability issues impact social workers across service settings and age groups, the lack of explicit linkages between foundation curriculum and disability studies in social work education presents as a significant gap. Building from our summary and review for how disability terminology, the social model of disability, and research may be incorporated into human behavior and the social environment competencies, we offer these final suggestions for how social work education could more explicitly integrate disability across the life span in the classroom:

- include the experiences of disabled individuals/communities across all ages as part of reviewing the developmental age groups;;
- discuss the similarities and differences between ageism, ableism, and paternalism to highlight the social justice implications of the language used and the caution of using developmental theories in pathologizing or labeling of clients;
- share information on social model of disability along with the biopsychosocial developmental theories to illustrate how these theories may lead to differing approaches for functional assessments, for case management and advocacy practices and for participation in interdisciplinary teams;
- role play interdisciplinary team conversations where the social work students practice professional skills of advocating, confronting, and educating colleagues from a social model of disability perspective while within a medical-based system;
- use 'communities for all' models and universal design as an example for how systems theories may guide interventions;
- discuss intersectionality of needs with both aging and disabled populations in course activities; and
- work with national organizations to specify educational competencies and practice behaviors for generalist social work practice that infuses disability across the lifespan terminology.

This establishment of a social model of disability as a foundation to our conceptual understanding as social workers is a crucial step to work with clients with disabilities of all ages because it offers core values, knowledge, and skills that cuts across service settings and social work practices.

Conclusion

Despite the aforementioned gaps in social work education that further silo the needs of disabled individuals, social work education is and can do more to highlight foundational content areas of disability across the life span. The possibility of integrating disability content across social work education may promote the inclusivity, intersectionality, effectiveness, and practice relevance. As social work continues to evolve, the potential for fostering workforce development that is intersectional across aging and disability may ultimately lead to improved well-being for clients of all ages—whether they have lived with lifelong disabilities or more recently acquired a cognitive, functional, or sensory impairment. We hope this review of terminology and practice frameworks may spur further discussions and offer concrete examples for integrating disability within our research and educational efforts.

References

Association of Gerontology in Higher Education (AGHE). (2014). *Gerontology competencies for undergraduate and graduate education*. Retrieved from http://www.aghe.org/images/aghe/competencies/gerontology_competencies.pdf

Attwood, T. (1998). *Asperger's syndrome: A guide for parents and professionals*. London, England: Jessica Kingsley.

Ball, S. (2012). *Aging in place: A toolkit for local governments*. Retrieved from http://www.aarp.org/content/dam/aarp/livable-communities/plan/planning/aging-in-place-a-toolkit-for-local-governments-aarp.pdf

Bean, K. F., & Krcek, T. E. (2012). The integration of disability content into social work education: An examination of infused and dedicated models. *Advances in Social Work*, *13*(3), 633–647. Retrieved from https://advancesinsocialwork.iupui.edu/index.php/advancesinsocialwork/article/view/2131/3906

Beaulaurier, R. L., & Taylor, S. H. (2001). Social work practice with people with disabilities in the era of disability rights. *Social Work in Health Care*, *32*(4), 67–91. doi:10.1300/J010v32n04_04

Brown, A. M. B. (2010). Respecting the students we serve: Using person first language. *National Association of School Psychologists Communique*, *38*(8), 32. Retrieved from http://www.communiquejournal.org/index.html

Brown, C., & Henkin, N. (2014). Building communities for all ages: Lessons learned from an intergenerational community-building initiative. *Journal of Community & Applied Social Psychology*, *24*(1), 63–68. doi:10.1002/casp.2172

Brueggemann, B. J. (2013). Disability studies/disability culture. In M. L. Wehmeyer (Ed.), *Oxford handbook of positive psychology and disability* (pp. 279–299). New York, NY: Oxford University Press.

Butler, R. (1969). Ageism: Another form of bigotry. *The Gerontologist*, *9*, 243–246. doi:10.1093/geront/9.4_Part_1.243

Cameron, R. P. (2014). Honoring the experience of disability. *Phi Kappa Phi Forum National Forum Journal*, *94*(2), 16.

Campbell, F. A. K. (2001). Inciting legal fictions: Disability's date with ontology and the ableist body of the law. *Griffith Law Review*, *10*, 42–62.

Campbell, F. A. K. (2008). Exploring internalized ableism using critical race theory. *Disability & Society*, *23*(2), 151–162. doi:10.1080/09687590701841190

Centers for Disease Control and Prevention. (2011). *Cognitive impairment: A call for action, now!* Retrieved from http://www.cdc.gov/aging/pdf/cognitive_impairment/cogimp_poilcy_final.pdf

Collier, R. (2012). Person-first language: What it means to be a "person". *Canadian Medical Association Journal*, *184*(18), E935–E936. doi:10.1503/cmaj.109-4322

Council of Social Work Education (CSWE). (2015). *Educational policy and accreditation standards for baccalaureate and master's social work programs*. Retrieved July 18 2016, from http://www.cswe.org/File.aspx?id=81660

Council on Social Work Education (CSWE). (2017). *Social work and integrative behavioral health care project*. Retrieved June 12 2017, from https://www.cswe.org/Centers-Initiatives/Initiatives/Social-Work-and-Integrated-Behavioral-Healthcare-P

Council on Social Work Education (CSWE) Gero-Ed Center. (2017). *Specialized practice curricular guide for gero social work practice: 2015 EPAS curricular guide resource series*. Alexandria, VA: CSWE.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*, 1241–1299. doi:10.2307/1229039

Davis, L. J. (Ed.). (2013). *The disability studies reader* (4th ed.). New York, NY: Routledge.

DeJong, G. (1979). *The movement for independent living: Origins, ideology, and implications for disability research*. East Lansing, MI: Michigan State University, Center for International Rehabilitation.

Dupre, M. (2012). Disability culture and cultural competency in social work. *Social Work Education: the International Journal*, *31*(2), 168–183. doi:10.1080/02615479.2012.644945

Ellis, C. (2010). Stroke in young adults. *Disability and Health Journal*, 3(3), 222–224. doi:10.1016/j.dhjo.2010.01.001

Feldman, P., Oberlink, M., Simantove, E., & Gursen, M. (2004). A tale of two older Americas: Community opportunities and challenges. In P. Feldman (Ed.), *Advantage initiative 2003 National survey of adults aged 65 and older*. New York, NY: Center for Home Care Policy and Research, Visiting Nurse Service of New York.

Gendron, T. L., Welleford, A., Inker, J., & White, J. T. (2015). The language of ageism: Why we need to use words carefully. *The Gerontologist*, Advance Access, 1–10. doi:10.1093/geront/gnv086

Gilson, S. F., Bricout, J., & Baskind, F. (1998). Listening to the voices of individuals with disabilities. *Families in Society: the Journal of Contemporary Social Services*, 79(2), 188–196. doi:10.1606/1044-3894.1818

Greene, R. R. (2014). Resilience as effective functional capacity: An ecological-stress model. *Journal of Human Behavior in the Social Environment*, 24(8), 937–950. doi:10.1080/10911359.2014.921589

Hayashi, R., & Kimura, M. (2004). An exploratory study on attitudes toward persons with disabilities among US and Japanese social work students. *Journal of Social Work in Disability & Rehabilitation*, 2(2–3), 65–85. doi:10.1300/J198v02n02_05

Hudson, R. (2014). The aging network and long term services and supports: Synergy or subordination. *Generations*, 38(2), 22–29.

Hutchison, E. D. (2017). *Essentials of human behavior: Integrating person, environment, and the life course* (2nd ed.). Los Angeles, CA: Sage.

Institute of Medicine (IOM). (2008). *Retooling for an aging America: Building the health care workforce*. Washington, DC: The National Academies Press.

Jackman, M. R. (1994). *The velvet glove: Paternalism and conflict in gender, class, and race relations*. Berkeley, CA: University of California Press.

Keenan, T. A. (2010). *Home and community preferences of the 45+ population. AARP research & strategic analysis*. Retrieved from http://assets.aarp.org/rgcenter/general/home-community-services-10.pdf

Kondrat, M. E. (2011). The bibliography of person-in-environment. *Oxford Bibliographies*. doi:10.1093/obo/9780195389678-0092

Kubiak, C., Rogers, A. M., & Turner, A. (2010). The learning experiences of health and social care paraprofessionals on a foundation degree. *International Journal of Lifelong Education*, 29(3), 373–386. doi:10.1080/02601371003700725

Lawton, M. (1974). Social ecology and the health of older people. *Social Ecology and Health*, 64(3), 257–260.

Lawton, M. P., & Nahemow, L. (1973). Ecology and the aging process. In C. Eisdorfer, & M. P. Lawton (Eds.), *Psychology of adult development and aging* (pp. 619–674). Washington, DC: American Psychological Association.

Lehning, A. J. (2012). City governments and aging in place: Community design, transportation and housing innovation adoption. *The Gerontologist*, 52(3), 345–356. doi:10.1093/geront/gnr089

Leonardi, M., Bickenbach, J., Ustun, T. B., Kostanjsek, N., Chatterji, S., & MHADIE Consortium. (2006). The definition of disability: What is in a name? *The Lancet*, 368(9543), 1219–1221.

Lesser, J. G., & Pope, D. S. (2011). *Human behavior and the social environment: Theory & practice* (2nd ed.). Boston, MA: Allyn & Bacon.

Mackelprang, R. M., & Salsgiver, R. O. (2015). *Disability: A diversity model approach in human service practice* (3rd ed.). Chicago, IL: Lyceum.

Mackelprang, R. W. (2010). Disability controversies: Past, present, and future. *Journal of Social Work in Disability & Rehabilitation*, 9(2–3), 87–98. doi:10.1080/1536710X.2010.493475

Mackenzie, R., & Watts, J. (2011). Is our legal, health care and social support infrastructure neurodiverse enough? How far are the aims of the neurodiversity movement fulfilled for those diagnosed with cognitive disability and learning disability? *Tizard Learning Disability Review*, 16(1), 30–37. doi:10.5042/tldr.2011.0005

McInnis-Dittrich, K. (2014). *Social work with older adults* (4th ed.). Boston, MA: Pearson.

Middleton, L. (1998). Services for disabled children: Integrating the perspective of social workers. *Child and Family Social Work*, 3, 239–246. doi:10.1046/j.1365-2206.1998.00078.x

Miller, P., Parker, S., & Gillinson, S. (2004). *Disablism: How to tackle the last prejudice*. New York, NY: Demos.

Millington, M. J., & Leierer, S. J. (1996). A socially desirable response to the politically incorrect use of disability labels. *Rehabilitation Counseling Bulletin*, 39(4), 276–282.

Morrow-Howell, N., & Pitt-Catsouphes, M. (2015, January). *Living longer: Opportunities for social work research and policy*. Opening plenary session. Society for social work and research annual conference. New Orleans, LA.

National Association of Area Agencies on Aging (N4A) and Partners for Livable Communities. (2007). *A blueprint for action: Developing a livable community for all ages*. Washington, DC Retrieved February 13 2012, from http://www.n4a.org/pdf/07-116-N4A-Blueprint4ActionWCovers.pdf

National Association of Social Workers. (2006). *Assuring the sufficiency of a frontline workforce: A national study of licensed social workers*. Retrieved from http://workforce.socialworkers.org/studies/nasw_06_execsummary.pdf

National Association of Social Workers. (2008). *Code of ethics of the National association of social workers*. Washington, DC: National Association of Social Workers.

National Association of Social Workers. (2010). *Social work profession*. Retrieved from http://www.socialworkers.org/pressroom/features/general/profession.asp

Null, R. (2013). *Universal design: Principles and models*. Boca Raton, FL: CRC Press.

O'Neill, J. V. (2002). Paraprofessionals: Answer to shortage? *National Association of Social Workers News*. Retrieved from http://www.socialworkers.org/pubs/news/2002/06/shortage

Oaks, D. (2012, August 28). *Let's stop saying "mental illness"! — MFI portal*. Retrieved from http://www.mindfreedom.org/kb/mental-health-abuse/psychiatric-labels/not-mentally-ill

Oldman, C. (2002). Later life and the social model of disability: A comfortable partnership? *Ageing and Society*, 22(06), 791–806. doi:10.1017/S0144686X02008887

Oliver, M. (1990, July 23). *The individual and social models of disability*. Paper presented at joint workshop of the Living Options Group and the Research Unit of the Royal College of Physicians. Retrieved from http://disability-studies.leeds.ac.uk/files/library/Oliver-in-soc-dis.pdf

Oliver, M. (2013). The social model of disability: Thirty years on. *Disability & Society*, 28(7), 1024–1026. doi:10.1080/09687599.2013.818773

Owens, J. (2015). Exploring the critiques of the social model of disability: The transformative possibility of Arendt's notion of power. *Sociology of Health & Illness*, 37(3), 385–403. doi:10.111111/1467-9566.12199

Putnam, M. (2007a). Preface. In M. Putnam (Ed.), *Aging and disability: Crossing network lines*. New York, NY: Springer Publishing Company.

Putnam, M. (2007b). Moving from separate to crossing aging and disability service networks. In M. Putnam (Ed.), *Aging and disability: Crossing network lines*. New York, NY: Springer Publishing Company.

Putnam, M., & Stoever, A. (2007). Facilitators and barriers to crossing network lines: A Missouri case study. In M. Putnam (Ed.), *Aging and disability: Crossing network lines*. New York, NY: Springer Publishing Company.

Rawlings, M. A. (2008). *Assessing direct practice skill performance in undergraduate social work education using standardized clients and self reported self-efficacy* (Doctoral dissertation). Case Western Reserve University. Retrieved from https://etd.ohiolink.edu/!etd.send_file?accession=case1216156818&disposition=inline

Richardson, V. E., & Barusch, A. S. (2006). *Gerontological practice for the twenty-first century: A social work perspective*. New York, NY: Columbia University Press.

Robbins, S. P., Chatterjee, P., & Canda, E. R. (2012). *Contemporary human behavior theory: A critical perspective for social work* (3rd ed.). Boston, MA: Allyn and Bacon.

Roos, E. M. (2005). Joint injury causes knee osteoarthritis in young adults. *Current Opinion in Rheumatology*, 17(2), 195–200. doi:10.1097/01.bor.0000151406.64393.00

Schalock, R. L., Borthwick-Duffy, S. A., Bradley, V. J., Buntinx, W. H., Coulter, D. L., Craig, E. M., … Yeager, M. H. (2010). Intellectual disability: Definition, classification, and systems of supports. Washington, DC: AAIDD.

Scharlach, A. (2012). Creating aging-friendly communities in the United States. *Ageing International*, *37*, 25–38. doi:10.1007/s12126-011-9140-1

Scheer, J., & Groce, N. (1988). Impairment as a human constant: Cross-cultural and historical perspectives on variation. *Journal of Social Issues*, *44*(1), 23–37. doi:10.1111/josi.1988.44.issue-1

Schriner, K. F. (1990). Why study disability policy? *Journal of Disability Policy Studies*, *1*(1), 1–7. doi:10.1177/104420739000100101

Schriver, J. M. (2004). *Human behavior and the social environment* (4th ed.). Boston, MA: Pearson.

Scotch, R. (2009). *From good will to civil rights: Transforming federal disability policy*. Philadelphia, PA: Temple University Press.

Shakespeare, T. (2006). The social model of disability. In L. Davis (Ed), *The disability studies reader* (4th ed.). New York, NY: Routledge.

Smart, J. (2011). *Disability across the developmental life span: For the rehabilitation counselor*. New York, NY: Springer.

Union of the Physically Impaired Against Segregation. (1974). *Policy statement*. Retrieved from http://disability-studies.leeds.ac.uk/files/library/UPIAS-UPIAS.pdf

United Nations Enable. (2006). *Eighth session of the ad hoc committee on a comprehensive and integral international convention on protection and promotion of the rights and dignity of persons with disabilities*. Retrieved from http://www.un.org/esa/socdev/enable/rights/ahc8.htm

United States Census Bureau. (2012). *Americans with disabilities: 2010*. Retrieved from http://www.census.gov/prod/2012pubs/p70-131.pdf

US Department of Housing and Urban Development (HUD). (2013). *Aging in place: Facilitating*. Retrieved from http://www.huduser.org/portal/periodicals/em/fall13/highlight1.html

Van Sluytman, L. G., & Torres, D. (2014). Hidden or uninvited? A content analysis of elder LGBT of color literature in gerontology. *Journal of Gerontological Social Work*, *57*, 130–160. doi:10.1080/01634372.2013.877551

Warner, L., & Shields, S. (2013). The intersections of sexuality, gender, and race: Identity research at the crossroads. *Sex Roles*, *68*, 803–810. doi:10.1007/s11199-013-0281-4

Watson, N. (2012). Researching disablement. In N. Watson, A. Roulstone, & C. Thomas (Eds), *Routledge handbook of disability studies* (pp. 93–150). New York: Routledge.

Wilkinson, J. A., & Ferraro, K. F. (2002). Thirty years of ageism research. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older adults* (pp. 339–358). Cambridge, MA: MIT Press.

Wolbring, G. (2008). The politics of ableism. *Development*, *51*(2), 252–258. doi:10.1057/dev.2008.17

Wolbring, G. (2012a). Ethical theories and discourse through an ability expectations and ableism lens: The case of enhancement and global regulation. *Asian Bioethics Review*, *4*(4), 393–399. doi:10.153/asb/2012/0033

Wolbring, G. (2012b). Expanding ableism: Taking down the ghettoization of impact of disability studies scholars. *Societies*, *2*(3), 75–83. doi:10.3390/soc2030075

World Health Organization. (2001). *International classification of functioning, disability, and health*. Geneva, Switzerland: WHO.

World Health Organization. (2002). *Towards a common language for functioning, disability and health*. Geneva, Switzerland: WHO. Retrieved from http://www.who.int/classifications/icf/en/