

# International Encyclopedia of Rehabilitation

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# **Models of Disability**

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## **Introduction**

In common language, disability most probably refers to the lack of a bodily part or function. Even speaking about “disability models” implicitly means that the word disability does not have a single meaning and that the meaning, possibly also the definition, depends on the model. The relativity of the meaning contrasts with common language. The 1986 edition of Merriam Webster's International Dictionary devoted over 28 lines to the descriptions of different meanings of the word disability, most of them not being related to common-sense language (legal meaning, disability caused by external factors, deficits in function, instead of lack of bodily parts, lacks related to external actions rather than belonging to the person e.g. impairments etc.).

Also the word handicap, used in common-sense language as a synonym of disability and impairment, has a complex and unstable meaning. This word dates back to 400 years ago in the English language and it has taken its place in common usage also in other languages like French, Italian and others. Recently, it has become a non-politically-correct word. The word “handicap” has had a curious and strange history which has links with begging, gambling and sport. Recent attempts of rejecting the term have come from the first meaning (begging), even though that is probably not the true origin of the term. According to some authors, the link with begging dates back to Henry VII, who authorized people to beg in the street (with “cap in hand”) only if they had an impairment. The Oxford English Dictionary links the etymology of “handicap” only to gambling and sport. The relationship with gambling dates back to 1652: reference was made to “the name of a kind of sport having an element of chance in it, in which one person challenged some article belonging to another, for which he offered something of his own, in exchange” (Barnes 1992, 1997). This kind of game was already popular in the 14<sup>th</sup> century, but it was not until 1652 that reference was found to the expression “hand in cap”: it was an old trading game, whose necessary equipment was a cap, two traders, a referee (matchmaker) and the action of putting and removing the hand from the cap during the bet time. In sport, the etymology of the word is related to bets, too. In the 18<sup>th</sup> century, more precisely around 1750, in horse races “handicap” referred to a disadvantage imposed from the outside to the best horse, with the aim of making the race more competitive. There was a “boot”, a difference in the weight carried by two horses, in order to make the match equal. The more successful the horse was, the heavier the boot it was assigned (Barnes 1992, 1997). As races started to be better organized, the matchmakers became professionals and they were called Handicappers. Only later was the race called Handicap race, too. In other words, in a handicap race a temporary “process of disablement” was organized in which a more able horse was “disabled” by carrying extra weight as a “handicap” in order to equalize the chances of the other competitors.

In those years, what still remained in the meaning of the word handicap? There were the referee, whose aim was to make the race fairer, the undetermined nature of the race with an element of chance in it, and the handicap being caused by an external factor. Only in the first years of the 20<sup>th</sup> century do we find a reference to disadvantage in humans: in 1915 a writer used the wording “handicapped child” for a learning disabled child. As we can see, the word is used as synonymous of impairment, “inside disadvantage”, or “stable” personal attribute.

The 1950s witnessed a growing interest about different meanings for both “handicap” and “disability”, and new models of disability and handicap or conceptualization on these semantic fields began to be built (Masala and Petretto 2008a, e, b). There were several reasons behind this interest: the census of the number of people needing help, and the estimation of the quality and quantity of help needed. In the “handy-cap matches”, professional matchmakers needed exactly to define the extra weight to be carried, in order to make the best horse similar to the other horses, whereas now, concerning humans, professionals need to be able to estimate the exact “weight” in order to reduce the difference between the person with an impairment and the other people.

### **From the Risk of Death to the Chronic Pathologies**

At the end of the first half of the 20<sup>th</sup> century but, most of all, after the 2<sup>nd</sup> World War, in parallel with the birth of social and health assistance, the need emerged to define eligibility criteria for various forms of social assistance, in order to provide support to those people who had suffered functional disorders from the War or due to other pathologies. Indeed, new epidemiological waves concerned pathologies and health in general, with a shift from typically epidemic pathologies to chronic pathologies and, as a consequence, the shift from the mere risk of death to the risk of important consequences in daily life and autonomy. In Europe and America, some people with pathologies lived in poverty because of their work impairment, or simply because of their difficulties to access the labor market. Their difficulties in the management of daily life activities were another reason for poverty, especially in industrially-based countries. In some instances, people with pathologies were also institutionalized and deprived of their personal freedom. This situation was also complicated by a widespread difficulty in defining the relationship between pathologies and functional consequences, and the exact weight of the different consequences of pathologies. Although specialists were somewhat interested in the relationship between pathologies and functional consequences, there were perhaps two or three different implicit and opposite beliefs. One belief was that a pathology necessarily implied functional consequences in general, and working consequences in particular, regardless of the severity of the pathology or other variables (e.g. socio-economic status, social network etc.). As a main consequence of this belief, people with pathologies were eligible for social aid and other kinds of assistance related to their pathologies, regardless of their actual functional status. That was probably the positive consequence of this approach; however, no interest was devoted to the process of stigmatization related to it. This approach was adopted by many specialists in the second half of the 20<sup>th</sup> century and, unfortunately, often also in the following years. A second belief, mainly adopted by people affected by pathologies, was based on the need not to live in poverty or in institutions. The first self-advocacy movements were launched in the 1960s and subsequently, aiming to defend the right of personal freedom and autonomy, despite limitations in functional activity, if any. This approach focused on the interest in the prevention of stigma and other processes of social marginalization related to the first approach, which was considered too “medical” in nature and not socially-based. Advocates of the second approach shifted their focus of interest on environmental factors that could lead to stigma and marginalization of people, thereby reducing their personal freedom. In Great Britain, a few self-advocacy associations of people with pathologies were spontaneously set up in those years, mainly aiming to fight the “paternalism” of the medical model. However, it was not until the 1970s that the work of the Union of Physically Impaired Against Segregation (UPIAS) was published in Britain (1976) and in the 1980s the so-called “Social Model of Disability” was created (Oliver

1983). In 1982 the Society for Disability Studies was founded in U.S.A. (Pfeiffer 2006). The social model highlighted the role of the environment in the disablement process, irrespectively of the level of impairment or functional limitation, and used the concept of “people being disabled by the environment”.

## **Pioneer Work in the 1970s**

A third approach was based on the need to better understand the link between pathologies and functional consequences, as well as to better analyze the different processes by which two persons with similar pathologies could have a very different functional status and, as a consequence, a very different quality of life (either objective or perceived). This approach can be perfectly summarized in the impressive work of Professor Saad Nagi, a sociologist of Egyptian origin and a pioneer in this field, whose contribution has been going on for over 40 years (Nagi 1965, 1991). Believing that medicine was exerting too strong a control over the issues linked to functional consequences, he decided to shift focus from the physical consequences of pathologies to the dynamic process that leads to functional consequences. He renamed this process “disablement” to highlight the dynamic nature of the process. Nagi's model aimed at describing the process whereby an individual with a specific active pathology can have some functional limitations and some disabilities. By doing so, he defined disability as an ‘expression of a physical or a mental limitation in a social context’ (Pope and Tarlov 1991) - a gap between the individual's capabilities and the demands created by the physical and social environment - and described disablement through four concepts: a) active pathology (a state of the body's defenses and coping mechanisms caused by infections, trauma, metabolic imbalance, degenerative disease processes, or other pathologies (Pope and Tarlov 1991)); b) impairment (a loss or abnormality at the tissue, organ, and body system level); c) functional limitation (the individual's ability to perform the tasks and obligations of his usual roles and normal daily activities - e.g. seeing, walking, listening, or in terms of disablement, i.e. limitations in performing socially defined roles (e.g. employment or self-care) (Pope and Tarlov 1991)) and d) disability. Those four words had been used as synonyms until then but, in the author's words, disability would be the expression of functional limitations in the social context, i.e. the product of the interaction between the individual and the environment that poses demands on individuals. This was the first version of Nagi's model; later in this paper we will describe other versions; however it is worth highlighting that this author has been a forerunner in acknowledging the role played by the social environment in the disablement process.

A few years later, in Great Britain, Amelia Harris made an epidemiological study of the relationship between pathologies and poverty in the population (Harris 1971). She used two different words: “impairment” (the loss of a limb, partially or wholly, or the presence of a dysfunctional limb, organ or body part) and “handicapped” (people who experienced difficulties in performing one or more functional activities, like self-care, using the toilet, eating, getting dressed, performing postural change or others). This author had the merit of distinguishing function from structure and correlating in some way a biological component with a functional one. In her epidemiological work, she categorized functional limitations related to daily life and labor life and highlighted the need for assistance concerning about half a million people. In the author's words, the word “handicap” was synonymous of “lack of ability”, no matter what the reasons were. In that sense, this work could be considered as reflecting the first previously described approach or belief. Her work received some criticism on methodology and choice of terminology, in particular from a research group of the University of Manchester that is remembered for its contribution to another approach to disablement, and is known internationally as Philip Wood's team at the Arthritis and Rheumatism Council Epidemiology Research Unit. Soon after, Wood became known internationally for his work for a new model developed under the aegis of the World Health Organization and named International Classification of Impairments, Disabilities and Handicaps (I.C.I.D.H.) (WHO 1980).

## **The I.C.I.D.H. Model in the 1980s**

The International Classification of Impairments, Disabilities and Handicaps (I.C.I.D.H.) was the first internationally shared conceptual formulation (it was translated into 13 languages) and it was the first internationally known system to classify the consequences of diseases. This model was aimed at analyzing, describing and classifying three different consequences of diseases: impairments (any loss or abnormality of psychological, physiological, or anatomical structure or function' (WHO 1980-1993)), disabilities ('any restriction or lack, resulting from an impairment, of ability to perform an activity in the manner or within the range considered normal for a human being' (WHO 1980-1993)) and handicaps ('a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual' (WHO 1980-1993)). These three different levels in the consequences of pathology are related to different levels of experience and of individual awareness. Although the text of the model proposed a mechanism of multiple links among the levels instead of a linear connection, in the graphic representation produced with the I.C.I.D.H. model there were linear and direct links among the three levels of pathologic consequences.

## **Social Models of Disability**

Together with the models previously described, there were in those same years some models elaborated by people who, because of their impairments and autonomy limitations, were the recipients of paternalist interventions and of actions that limited their freedom and their human and social rights. In fact the countries analyzed so far were recording a strong trend towards institutionalizing those people who suffered from functional limitations and towards marginalizing them. In the 1970s, Britain saw the birth of 'Disabled People's International' (DPI), which was paralleled by the 'Society for Disability Studies' (SDS) in the USA in the 1980s. DPI formed UPIAS ('Union of the Physically Impaired Against Segregation') that, in 1975, developed its own disablement model that is now renowned internationally as the 'social model of disability' as fully opposed to what they themselves defined as the 'medical model of disability' (Oliver 1983). According to this model, some people suffering from functional and structural impairments are deprived of their authority and forced to play secondary roles in society on the basis of physicians' and health professionals' decisions that influence all the aspects of their lives. To fight this traditional way of behaving against the people with functional and structural limitations, the members of UPIAS developed a two-tier concept model composed of impairment and disability (UPIAS 1976).

The members of UPIAS were the toughest opposers of the subsequent ICIDH model by the World Health Organization, since this was another example of an individualistic approach with a medical base, and contained an explicit reference to the causal and direct link between impairments, disability and handicap whereby impaired people were made responsible of their reduced integration into society. On the contrary, they tried to disseminate a vision where the physical and social environment shapes the difficulties that people with functional limitations or impairments encounter, so they tried to eliminate the causal relation between impairment, disability and handicap. To define the disablement process they adopted the term 'disabled' in the sense of being deprived (by the environment) of the capability or of the possibility to perform a specific task. The US movement was called 'Society for Disability Studies'. Some differences can be detected between the British approach and the US one, however a clear-cut distinction is difficult to make between the two approaches. They share the attempt to go beyond the medical model, since this model is highly individualized and puts the blame on the individual. These approaches highlighted how individualistic the concept of disability had been so far, since it focused on what was seen as an inborn deficit and on the ways to improve it, without taking the social process that disables people into consideration. Though differing, the two approaches see disabled people as those who

experience disablement following some restrictions created by society.

## **Revisions of Previous Models in the 1990s**

The I.C.I.D.H. model was soon widely criticized, above all for its supposed logic of a linear link among the levels, the overlapping of levels and the ambiguous definition of handicap. Indeed, though handicap was defined as the socialization of the experience of an illness and a 'disadvantage', the fact of pointing to it as deriving from impairment or a disability and of linking it to the missing performance of survival tasks introduced unforeseeable connections between the disease and the disadvantage in the individual. This model received criticism and, above all, the firm opposition of self-advocacy movements and activist groups, who saw in it the basis for further discrimination against people with impairments. It soon underwent a revision and in 1993 a new version was published with a preface acknowledging the shortcomings of the previous version and listing the points to be dealt with in the revision work to come (WHO 1980-1993).

In the same years there was an important wave of revisions also for other models aiming to include the role of social and physical environment in the disablement process. Nagi's model was revised by the author himself, by the IOM and by Verbrugge and Jette as well (Pope and Tarlov 1991, Verbrugge and Jette 1994).

Nagi himself made a review of his model in 1991, the year in which his model was accepted by IOM within the report 'Disability in America' (Nagi 1991, Pope and Tarlov 1991). In his revision, the author aimed at clarifying the role of environmental factors in the process of disablement: 'Disability refers to social rather than organismic functioning. It is an inability or limitation in performing socially defined roles and tasks expected of an individual within a socio-cultural and physical environment. These roles and tasks are organized in spheres of life activities such as those of the family or other interpersonal relations; work, employment, and other economic pursuits; and education, recreation, and self-care' (Nagi 1991). In his work, the author also explained a non-linear link between the levels he had described: not all impairments or functional limitations result in a disability and similar patterns of disability may result from different kinds of impairments and limitations in function. (Nagi 1991). The author also listed some factors that could favor and mediate the link between impairments, functional limitations and disabilities. He introduced the role of an individual's characteristics, of his/her reactions and the role of the environment, which was further divided into social environment (reactions and expectations of reference individuals) and physical environment (which can be made worse by physical barriers).

At the beginning of the 1990s, another conceptual contribution was made on disablement, namely by the National Center for Medical Rehabilitation Research (NCMRR) of Bethesda, which was aimed at studying rehabilitation to improve its scientific and epistemological quality. NCMRR developed a model that describes disability and was based both on Nagi's model and on the I.C.I.D.H., in an attempt to overcome the limits of both: more precisely, the fact of assuming a linear causal relationship among the various consequences of pathologies, and failing to analyze the role of environmental factors in the dynamics of the relationships among the various levels (NCMRR 1993). The new model focused on individuals, and on the way they adapt to the functional limitations in their own families, in the working environment and in the community. This model hypothesized five domains connected one to the other by overlapping points, multiple links and bi-directional links: pathophysiology, impairment, functional limitations, disability and social factors. The authors of the model described disability as 'a limitation in performing tasks, activities, and roles to levels expected within physical and social contexts' (NCMRR 1993). Function meant 'the execution of an action' (NCMRR 1993). Like previous models, the NCMRR model described impairment as 'a loss or abnormality at the organ or organ system level of the body. Impairment may include cognitive, emotional, or physiological function, or anatomical structure, and include all losses or abnormalities, not just those attributable to the initial pathophysiology' (NCMRR 1993).

Pathophysiology was meant as 'the interruption of, or interference with, normal physiological and developmental processes or structures' (NCMRR 1993). This model also studied the role of societal limitations in an original way as against the previous models, so as to analyze a basic link between an individual's adaptation to disability and the social barriers that disabled people run into and that may restrict their opportunities and their achieving an adequate quality of life. Some personal factors were described, too, which may influence the relationship among the domains and, more specifically, an individual's response to a specific situation: organic factors, psycho-social factors and personal environmental factors. According to the NCMRR model, the interaction among all of these factors would produce the individual's response to impairment; each factor may influence the ability of an individual to adapt to life and to the community, and to reach a good quality of life.

As already written above, about one year later a second revision of Nagi's model was developed by Verbrugge and Jette. While integrating this model with I.C.I.D.H., they developed a new disablement model in order to describe how chronic and acute conditions affect functioning in specific body parts, mental function and daily life, and the role of personal and environmental factors in disablement (Verbrugge and Jette 1994). In fact, they too, like Nagi, saw disability as a gap between the capabilities of an individual and the demands made by the social and physical environment; and they tried to describe some of the variables that can mediate the disablement process, by acting as a moderator and a mediator in the relations between pathology, impairment, functional limitation and disability. They also described the factors preceding the onset of disablement, e.g. the individual's lifestyle or socio-demographic and biological factors, which may constitute risk factors or predisposing factors. Other factors are related to the process already under way and may be divided between intra- and extra-individual ones; moreover, since they can limit or exacerbate the disablement process, they are classified as interventions or as exacerbating factors. The intra-individual factors operate within a person, such as for example the lifestyle, or coping strategies, while extra-individual factors concern the physical and social setting where the process takes place (quality of the therapeutic regimen, the social network the individual belongs to and the physical environment where he/she lives). The whole set of risks or predisposing factors and of intra- and extra-individual factors can operate on all four levels of the main path, as discussed above. The interaction among all of these levels starts the Disablement process. Individuals sharing the same active pathology, or impairment, or functional limitation, might experience different levels of disablement according to the influence of the predisposing risk factors, or of intra- and extra-individual factors.

A third revision of Nagi's model was made in 1997 by Brandt and Pope of IOM (1997). They wondered whether disablement was an inevitable consequence of pathologies (on the basis of the vicious circle of disablement), or whether this vicious circle could be broken in order to activate a virtuous circle of enablement. A new model was developed, aiming to describe disablement as a consequence of the interaction between the individual and the environment. The new model had three dimensions, i.e. the individual, the environment and the interaction between the individual and the environment, from which disablement can derive. As for the 'individual' dimension, it included the main path linking pathology, impairment, functional limitation and non-disability. The links among the various levels were identified by means of two-direction arrows, to highlight mutual influences and to cancel linear causality of the links among the various levels. Moreover if, on the one hand, the disability level was cancelled, on the other the non-disability level was introduced before pathology, to point out the starting point from which functional limitations were missing. Beside the main path, risk factors were placed, which are here called transitional factors to specify their role in causing a transition among the various levels and to point out that there can be both disabling or risk factors (those increasing the likelihood that a person has some functional limitations) and enabling factors (those increasing the likelihood that the process does not start, leading from a non-disability status to functional limitations). In the 'environment' dimension, a distinction was made between the physical and the social-psychological environments. Environment

was compared to a carpet or mat, the strength or resistance of which is proportionate to the quality and the quantity of the support systems and of the various barriers. The meeting between an individual, who has some potentially disabling conditions, and the environment may give origin to a stronger or a weaker disablement, depending on whether the environment is more or less supportive or upon the presence of many or few barriers (in the mat metaphor, this is represented by how deep the person sinks into the mat). Therefore, given the same impairments and/or functional limitations, there can be different levels of disablement according to the relationship between the individual and the environment. In the metaphor of the mat, each social-psychological or physical factor represents one layer of the mat, the absence or the lack of which causes the support to become weaker and entails some problems when the individual interacts with the environment (Brandt and Pope 1997). It should be noted that while there are multiple links among the different levels described in the individual dimension (non-disability, pathology, impairment and functional limitation), there are also some multiple links between the individual and the environment, therefore the environment can have a positive or a negative influence on each level of the individual. According to this model disablement is no longer part of the individual, but it is rather a function of the interaction between the individual and the environment, a dependent variable the value of which is calculated on the basis of the interaction between the two variables (the individual and the environment) (Brandt and Pope 1997). There is no doubt that considering disablement as the result of the interaction between the individual and the environment is the original element in the work by IOM in 1997, as against previous contributions.

In parallel with the reviews of Nagi's model and the works by the IOM, the complete revision of the I.C.I.D.H. was undertaken, also thanks to the work of different collaborative groups distributed all over the world. In the same years and as a result of debates about I.C.I.D.H.'s revision process, another model was developed by a group coordinated by Patrick Fougeryrollas (Fougeryrollas, 1995). This model, now known as 'Handicap Creation Process' (or 'Processus de création du Handicap' in French-speaking countries), is a person-environment-interaction model by which the author describes the role of environmental factors in the disablement process (Fougeryrollas 1995). The dimensions analyzed by the models are risk factors, personal factors (related to organic systems, functional capabilities and socio-cultural identities), environmental factors and life habits (activities and social roles). The interaction between personal factors and environmental factors may influence an individual's habits, either fostering full social participation or creating a situation of handicap (Fougeryrollas 1995).

As a result of the revision process of I.C.I.D.H., a second version renamed I.C.I.D.H.-2 was created with a new terminology on dimensions. Soon a new title was also suggested: International Classification of Functioning, Disabilities and Health (ICF). Eventually, in 2001, it was presented during the Assembly of the World Health Organization (WHA resolution 54.21) (WHO 2001). It is now published and used in 191 countries all over the world. ICF defines health conditions and the states that are associated to them. Health conditions are defined as 'an umbrella term for disease (acute or chronic), disorder, injury or trauma', but also 'other circumstances such as pregnancy, ageing, stress, congenital anomaly, or genetic predisposition' (WHO 2001). To analyze health conditions and health-related states, the model refers to two far-embracing terms: disablement and functioning. Disablement is the interaction between the individual, with his/her health conditions, and the environment (in its negative aspects), while functioning is the same interaction but in positive terms. ICF describes human functioning and its limitations as the result of the dynamic interaction between health conditions and contextual factors. To this aim, some domains are analyzed and described under the perspective of the body, the individual and society: body functions, body structures, activities, and participation respectively. Body functions are defined as 'the physiological functions of body systems (including psychological functions)' (WHO, 2001). Body structures are 'anatomical parts of the body such as organs, limbs and their components' (WHO 2001). Alterations in body structures and functions are called impairments. Moreover, the

model makes a classification of activities and of participation. Activity is defined as 'the execution of a task or action by an individual' (WHO 2001). And participation is 'involvement in a life situation' (WHO 2001). They can both encounter problems that are described, respectively, as limitations of activities ('difficulties an individual may have in executing activities') and restrictions in participation ('problems an individual may experience in involvement in life situations') (WHO 2001). The distinction between activity and participation is one of the least clear points in this new model, since there is only one classification for both, although different options for distinction are suggested to the codifier, but the distinction between capacity and performance reduces part of this ambiguity. Capacity is meant as 'an individual's ability to execute a task or an action. This construct aims to indicate the highest probable level of functioning that a person may reach in a given domain at a given moment. To assess the full ability of the individual, one would need to have a 'standardized' environment to neutralize the varying impact of different environments on the ability of the individual' (WHO 2001). Performance is defined as 'what an individual does in his or her current environment. Because the current environment includes a societal context, performance can also be understood as "involvement in a life situation" or "the lived experience" of people in the actual context in which they live (WHO 2001). The gap between capacity and performance is the impact of the environment and it can provide some useful information on the intervention that is liable to modify the environment and, thus, improve performance. The ICF model also analyzes the relationship between the individual and the environment, describing contextual factors, which are divided into personal and environmental ones. Contextual factors are defined as 'the complete background of an individual's life and living' (WHO 2001). Environmental factors are meant as 'the physical, social and attitudinal environment in which people live and conduct their lives' (WHO 2001). They represent all that surrounds a person and that may have some influence on the functioning of the individual and, therefore, on his/her body structures and functions, on his/her capabilities (as an individual or as a member of a social group). These influences can be either positive or negative, depending on whether these factors operate as facilitators or as barriers (and this is exactly how they are described in the ICF model). As already written above, ICF defines disablement as the result of the interaction between the domains of the body, individual and environment.

## Conclusions

In the 20<sup>th</sup> century, an important scientific debate took place on diseases and their consequences, and it generated various conceptual models. The aim of these models was the description of the relationship between pathology and functional consequences. However, there are differences in the level of analysis of this relationship: most of the early models analyzed the relationship only at the surface level; later models, and some previous exceptions, analyzed the relationship in a deeper way. The models took inspiration from various sources: the two models developed under the aegis of the World Health Organization are probably the best known internationally, but there are also other important conceptual elaborations in the field, created by specialists and by self-advocacy organizations. While the specialist models aimed at defining the criteria of eligibility for various forms of assistance and aid (welfare services and economic aid), conceptual models elaborated by self-advocacy organizations aimed at defining the inalienable rights of people with disabilities and measures against marginalization and stigmatization, as well as reducing the gap between need and interventions.

These different contributions could be divided into three groups of models: models in which disability is an attribute of the person, models in which disability is related to the environment, and models in which disability is linked to the person-environment relationship. All newer models are likely to belong to the third group. With the aim of favoring a person-environment relationship which could enable people to meet their personal needs and projects, there is a growing search for analytical conceptual models that could describe the dynamics of disablement and of related variables, as well as the need for a common language among disablement specialists.

Indeed, a good knowledge of semantics related to disability is necessary in special fields and also in common-use language, as the use of synonyms could inevitably lead to stigmatization. Another negative consequence is losing the possibility of analyzing how the environment and society have their responsibility in disablement processes and, in positive terms, in enablement processes.

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