

**Demystifying disability: A review of the International Classification of Functioning,
Disability and Health?**

by

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Abstract

The paper describes and evaluates the theoretical underpinnings of the International Classification of Functioning, Disability and Health (ICF), and develops the proposition that its conceptual framework provides a coherent, if uneven, steer through the competing conceptions of disability. However, to date, there has been little evaluation of the theoretical efficacy of the ICF. In seeking to redress this, the paper develops the argument that the ICF fails to specify, in any detail, the content of some of its main claims about the nature of impairment and disability. This has the potential to limit its capacity to educate and influence users about the relational nature of disability. The paper develops the contention that three parts of the ICF require further conceptual clarification and development: (a). (re) defining the nature of impairment; (b). specifying the content of biopsychosocial theory; and, (c). clarifying the meaning and implications of universalisation as a principle for guiding the development of disability policies.

Key words: disability, impairment, World Health Organisation, biopsychosocial theory, universalisation.

(1). Introduction

Theoretical claims and debates about the nature of disability are predominantly characterised by perspectives that conceive of mind, body, and society as separate spheres of human existence. In particular, disability theory tends to revolve around the dichotomy of medical and social conceptions of disability. Whereas the former relies on a naturalistic conception of disability, that biology is at the root of impairment that, in turn, causes disability, the latter defines disability as a social construction through which society oppresses disabled people. Both conceptions, while capturing aspects of disabled people's lives, are problematical for failing to recognise that biology and society are entwined in a dialectical relationship. This implies that physical and mental impairment, in contributing to functional limitations of bodies, cannot be discounted as ephemeral in the construction of disability and disabled people's lives. Rather, a focus on interactions between functionally impaired bodies and socio-cultural relations and processes is seen, by some, as crucial in the development of a non-reductive and non-essentialised understanding of disability.

These ideas are gaining ascendancy in a range of important contexts, most notably in the World Health Organisation's (WHO, 2001) International Classification of Functioning, Disability and Health (ICF). This replaces the WHO's (1980) original classification, the International Classification of Impairments, Disabilities, and Handicaps (ICIDH), which has largely been dis-credited for its medical tenor and for focusing on the limitations of

people's abilities as the key determinant of disability. Thus, as Bickenbach, et al (1999: 1176) note, the ICIDH is problematical because it fails to 'acknowledge the presence of social barriers' in influencing disability. In contrast, the ICF, so it is claimed, seeks to develop the conception that 'mind, body, and environment are not easily separable but rather mutually constitute each other in complex ways' (Marks, 1999: 25). In this sense, the ICF conceives of disability as 'a compound phenomenon to which individual and social elements are both integral' (Bickenbach, et al, 1999:).

This is, potentially, an important conceptual development because of the diverse ways in which the WHO, through tools such as the ICIDH, is able to influence public policy worldwide. As Bickenbach, et al (1999: 1174) note, the ICIDH has been used by governments for a 'wide variety of purposes - health outcomes research, population surveys...and as an organisational basis for social policy'. In the UK, for instance, the ICIDH's functional-limitations perspective of disability, which espouses individual adjustment and coping strategies as policy priorities, has been adopted by the Office for Population Censuses and Surveys (OPCS, 1993) and other government departments. Not surprisingly, much health care and social policy in the UK, in following the tenets of the ICIDH, conceives of disability and handicap as being caused by impairment and, as a consequence, requiring appropriate medical intervention and treatment. To the extent that the ICF's conceptual foundations are a departure from the reductive frameworks of ICIDH they are, then, like their predecessor, likely to have some impact on the shape of future health and social policy programmes in relation to disability.

However, to date, there have been few, if any, commentaries or evaluations of the theoretical and conceptual underpinnings of the ICF, and the extent to which they provide the basis for a coherent understanding of the nature of disability and impairment in society (although, see Bickenbach, et al., 1999, in relation to the ICIDH). This paper, therefore, seeks to redress these lacunae by describing and evaluating the core theoretical underpinnings of the ICF, and by suggesting how they can be developed further in contributing to an enhanced understanding of impairment and disability. In developing these points, I divide the paper into two main parts. I begin by providing a brief overview of the parlous states of disability theory that the ICF is seeking to circumvent. As I suggest, the ICF's conceptual framework provides a coherent, if uneven, steer through the competing discourses of disability and, in doing so, it demonstrates, in part, the 'value of theoretical openness to different levels of explanation' (Marks, 1999: 26).

The paper proceeds to qualify this statement by noting that the ICF's explanatory and practical utility is likely to be limited unless some of its core concepts and principles are developed further and justified. The ICF is relatively silent about its conceptual underpinnings, and it is possible that different practitioners will interpret, in quite contrasting ways, some of its theoretical and conceptual content. This is particularly so in relation to three of the ICF's principal conceptual elements, in which, as I shall argue, greater clarity about them, their meaning, and their theoretical adequacy, is required:

these elements are; the definition of impairment; biopsychosocial theory; and, principles of universalisation as the basis for disability health and social programmes.

(2). Situating ICF in competing discourses of disability

Discourses of disability are characterised by a myriad of competing and often conflicting viewpoints on the nature and determinants of disability. These range from western biomedical discourses (Rhodes, 1985), which conceive of disability as a state of dysfunctioning body parts, to social perspectives which see disability as society's denial of opportunities to those with impairment (Oliver, 1990) (1). Between these extremes, a range of views are evident, including perspectives which regard disability as a form of social deviance (Goffman, 1963), to traditions within social psychology that emphasise the interactive nature of disability (Safilos-Rothschild, 1970). More recently, post-modern and post-structuralist discourses, which conceive of disability as a series of socio-cultural constructions, have gained some ascendancy (Butler, 1993, Paterson and Hughes, 1999).

Foremost, western bio-medical discourses have been highly influential in contributing to explanations about the nature of disability. They stem from the medical profession and reflect its interest in the impaired, or functionally limited, body as an object of scientific interest, classification, and medical intervention. A bio-medical understanding of disability reduces impairment to categories of the diseased body and 'focuses on the

patient not the person' (Nettleton, 1995: 34). Disability, then, is understood to be a consequence of the biological malfunctioning of bodily organisms. Such discourses encourage the study of how chronic and acute conditions affect bodily functions, and the implications for a person's movement, mobility, and independence (Imrie, 2000). The role of the doctor is paramount in seeking to repair the disabled or dysfunctioning body, or a corporeality that is seen as a deviation from 'normality'.

Biomedical conceptions of disability have been the subject of much well documented comment and critique (Oliver, 1990, Zola, 1972) (2). For some, biomedicine is problematical for labelling disabled people with inappropriate, medical, categories, such as 'spina bifida' and 'tetraplegic', which, as Brisenden (1986: 21) notes, 'are nothing more than terminological rubbish bins into which all the important things about us as people get thrown away'. For others, biomedicine does no more than pathologise disability and 'blame the victim' for their condition (Abberley, 1987). In contrast, some commentators note that disability is not necessarily a function of a disease or medical condition, but may well be related to the influence and effects of social, psychological, and environmental factors (Bickenbach, 1993). In this sense, biomedicine is seen as providing an 'under-socialised' account of disability by failing to theorise the interrelationships between biology, culture, and biography.

Such observations were part of the disquiet with the theoretical underpinnings of the ICIDH (Oliver, 1990, Pfeiffer, 1998). While the intent of the ICIDH was to develop a non

medical conception of disability, it tended to convey a reductionist understanding of handicap as the social disadvantages 'stemming from the presence of impairments and disabilities' (WHO, 1980: 29). This located the source of disability primarily within the malfunctioning of the biological body, while playing-down the effects of broader social and environmental contexts. For others, the ICIDH was equally problematical for uncritically reproducing the biomedical notion that disability is 'not normal', or that disabled people are the problem for deviating from the standard norms of biomedical measurement (Abberley, 1987). Thus, for Oliver (1990: 4) the ICIDH conceives of 'disability as not being able to perform an activity considered normal for a human being, and handicap as the inability to perform a normal social role'.

The notion of disability as an individual abnormality is, however, not confined solely to biomedical discourses. Aspects of social psychology have developed biomedical insights, though, usually, by abstracting an understanding of the body from its socio-cultural contexts. Thus, Anderson and Clarke (1982) show how low self-esteem is a characteristic of adolescents, while Kasprzyk (1983) indicates how despondency is a more or less recurrent state among people with spinal injuries. Moreover, experimental social psychologists, in attempting to simulate disabilities, have concluded that disabled people arouse anxiety and discomfort in others and, as a result, are socially stigmatised (Kasprzyk, 1983). For Fine and Asch (1988), such research reveals little about how disabled people engage in meaningful social interactions. They also note that 'disability is portrayed as the variable that predicts the outcome of social interaction when, in fact,

the social context shapes the meaning of the disability in a persons life' (Fine and Asch, 1988: 19).

These views, in part, have formed the cornerstone of discourses of disability derived from medical sociology, and its focus on the sociology of disease, chronic illness, and disability (Bury, 1997, Zola, 1972). Far from reducing disability to the specific limitations of physical and cognitive functions, medical sociology has sought to explore the broader interrelationships between the body, self, and society. For Bury (1997: 121), this has signalled 'a concern with the meaning of disability and not simply its definition and prevalence'. Thus, aspects of medical sociology have been inclined to investigate the socio-cultural origins, and significance, of disease categories. In this sense, the meaning of disability is entwined with the role of medical care and its labelling. In particular, research has revolved around the study of interactional relations, or how disabled people's identities, for example, have been spoiled by negative and socially stigmatising encounters (Wiener, 1975).

Such ideas, in part, underpin the ICF and its desire to distance itself from the notion that the malfunctioning biological body, in and of itself, is the primary determinant of disability. Instead, the ICF, as the next section indicates, seeks to locate an understanding of disability at the intersection between the biological body and social and institutional structures. This reflects part of the medical sociological, and other, traditions, and the concern with 'the policy implications of the meaning of disability' (Bury, 1997: 123).

Thus, Blaxter (1980) highlights the important role of professionals and policy agencies in constructing meanings of disability, or of how disabled people's experiences of disability are conditioned, in part, by bureaucratic procedures. For others, the meaning and experiences of disability are linked to, and mediated by, other social variables such as class, ethnicity, geographical location, and gender (Morgan, 1996). Thus, an understanding of the incidence and nature of disability is, so some argue, related to the link between health and socio-economic circumstances

However, for Armstrong (1987), much of medical sociology is limited in that it rarely questions the biological vision of the body held by health, and related, professionals. This observation underpins, in part, the development of perspectives that understand disability as socio-cultural and political restrictions that inhibit opportunities for social participation. For instance, the presence of steps into a shop prevent wheelchair users from entering it; such barriers, so it is argued, reflect thoughtless design and indifferent social attitudes towards disabled people (Imrie, 2000). Disabled people, then, are an oppressed minority who experience disadvantage or, as Hurst (2000: 1084) suggests 'disability is something that happens to you, not something you have'. At its extreme, social discourses of disability have rejected the relevance of biology and the body as organic matter in understanding aspects of disability. Rather, as Hughes and Paterson (1997: 331) note, impairment has tended to be seen as form of deviance, 'possibly of doubtful ontological status and therefore of little sociological interest'.

The social theory of disablement has limited appeal for the ICF because it separates the biological from the social or, as Hughes and Paterson (1997: 329) note, it 'proposes a disembodied subject, or more precisely a body devoid of history, affect, meaning, and agency'. For Oliver (1990: 45), for example, 'disablement has nothing to do with the body' and bodily impairment is 'nothing less than a description of the physical body'. This, then, mirrors the reductionism of biomedicine in treating the (impaired) body as an 'inert, physical object, as discrete, palpable and separate from the self' (Hughes and Paterson, 1997: 329). However, as some commentators note, the impaired body is much more than just a physiological phenomenon; it is also a socialised subject and a discursive construction (Williams, 1999). In this, I concur with the architects of the ICF (Bickenbach, et al, 1999: 1187), who note that 'a social theory of disablement risks incoherence if it cannot make the link...between impairments and the socially-created disadvantages of disablement'.

New directions in medical sociology are increasingly developing such links. In particular, the rise of post-modern critiques of modernity and modernist human sciences have encouraged pluralistic approaches to the study of the body in relation to health, disease, and disability. Thus, the impaired body is increasingly conceived of as neither medical nor social, mental or physical, but as an intersection of the biological, psychological, and social. Kelly and Field (1996), for instance, note that social and biological facts ought to be incorporated into an analysis of the body. Grosz (1994) also comments that the body should be seen as a 'site of contestation' or reactive to social

processes. She points the way to re-figuring the relationship between the biological and societal by suggesting that 'the openness of organic processes to cultural intervention, transformation or even production, must be explored' (Grosz, 1994: 23). Elias (1991) also notes that our capacity for language and consciousness are contained within, and are limited by, our bodies. Likewise, Shilling (1993: 9) suggests that any theory of human agency or action requires an account of the body, that 'acting people are acting bodies'.

These accounts suggest that disability is a complex, multi-dimensional, phenomenon that cannot be easily understood by recourse to the unequivocal messages of the contrasting models or discourses of disability. The dominant discourses of disability (i.e. the medical and social models) are characterised by unambiguous modes of expression in a world where, as Bauman (1992: 120) argues, 'ambiguities cannot be wished out of existence'. Rather, the multi-dimensional nature of disability suggests that, at the very least, some attempt to reconcile competing perspectives be the basis for the development of disability theory, sentiments that are echoed by the ICF.

(3). ICF: beyond reductive conceptions of disability?

The ICF's classification covers any disturbance in terms of functional states associated with health conditions at body, individual, and society levels. Functional states include body functions and structures, activities at the individual level, and participation in society. As the ICF suggests, disability is the variation of human functioning due to one

or a combination of the following: that is, the loss or abnormality of a body part (i.e. impairment); difficulties an individual may have in executing activities (i.e. activity limitations); and/or problems an individual may experience in involvement in life situations (i.e. participation restrictions). As Bickenbach, et al (1999: 1184) comment, 'the three dimensions are co-equals in significance and...are different facets...of a single emergent phenomena, disablement'. The ICF also notes that variations in human functioning (i.e. disability) are influenced by contextual factors, including environmental factors or aspects of the external or extrinsic world such as social systems and services, and personal factors, such as age, ethnicity, gender, social status, etc.

The ICF departs from the ICIDH in a number of significant ways. Foremost, unlike the ICIDH, it does not conceive of the body as pre-social, or impairment as beyond socio-cultural influences or conditioning. Rather, for the ICF, disability is a relational phenomenon whereby the functional limitations of impairment become disabling as a consequence of broader social and attitudinal relations. Thus, as the ICF (2001: 221) notes, disability is 'the negative aspect of the interactions between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)'. The ICF (2001: 13) also challenges the medical tenor of the ICIDH by noting that the presence of impairment 'does not necessarily indicate that a disease is present or that the individual should be regarded as sick'. In contrast, the ICF (2001: 25) proclaims that 'the issue is therefore an attitudinal or ideological one requiring social change, which at a

political level becomes a question of human rights. Disability becomes, in short, a political issue’.

These proclamations are, potentially, far reaching and seek to develop an understanding of disability in which the dualisms of the medical and social models are disbanded. However, these developments have not prevented a range of criticisms being levelled at the forerunner to the ICF, the Beta-2 Draft of the ICIDH-2 (Bury, 2000, Pfeiffer, 2000). These range from fundamental objections, or where the ICIDH-2 is dismissed as no more than the continuation of the medical model, to points of detail about the ICIDH-2’s practical and operational utility. Thus, Pfeiffer (2000: 1081) dismisses the ICIDH-2 with the astonishing, yet unsupported, claim that it is ‘a declaration of the ideal of eugenics’. For other, such as Bury (2000), the ICIDH-2 does little to advance the ICIDH and only serves to reaffirm the principles of this original framework. He also notes the vagueness of concepts in the ICIDH-2, such as ‘activities’ and ‘participation’, and doubts whether they can capture the panoply of disadvantages that underpin the lives of disabled people.

These comments, however, ought to be seen as part of an ongoing debate about the role and significance of the ICF. Indeed, the ICF is far from a finished product and parts of its theoretical and value-bases require some amplification and clarification (see, Fougeryrollas and Beauregard, 2001). However, to date, there has been little evaluation of the theoretical efficacy of the ICF. In seeking to redress this, the paper develops the

argument that the ICF fails to specify, in any detail, the content of some of its main claims about the nature of impairment and disability. This has the potential to limit the ICF's capacity to educate and influence users of the document about the relational nature of disability. Three parts of the ICF, to my mind, require further conceptual specification and development: (a). (re) defining the nature of impairment; (b). specifying the content of biopsychosocial theory; and, (c). clarifying the meaning and implications of universalisation as a principle for guiding the development of disability policies. I discuss each of these in turn.

(a). Redefining the nature of impairment

One weakness of disability studies is the limited theoretical engagement with the concept of impairment (Crow, 1996, Hughes and Paterson, 1999). As Thomas (1998) notes, there are different ways of thinking about impairment, from those who conceive of it as a fixed and irreducible difference between disabled and non disabled people, to those who see it as no more than a socially constructed (or non biological) difference. Thus, for Crow (1996: 60), impairment is an 'objective concept which carries no intrinsic meaning', while, for Boorse (1987: 372), the definition of impairment, as a variation from species typical functioning, 'is value-neutral, or as value-neutral as biology itself'. In contrast, some social theoretical accounts of disability are dismissive of impairment as an analytical category, and discount it as a contributory factor in causing disability (Oliver, 1990, Pfeiffer, 2000). Thus, for Oliver (1990: 42), restrictions of activity

experienced by people with impairments are wholly due to social and attitudinal barriers.

The ICF seeks to steer a middle way through these perspectives in that limitations of impairment are related to interactions between biology, personal factors, and broader environmental constraints. However, at the level of body functions and structures, the ICF subscribes to the value-neutral account of impairment, or that a person classified as impaired is, objectively, defective. For the ICF (2001: 221), impairments are biologically derived and defined and are 'problems in body function or structure as a significant deviation or loss'. The classification of impairment is, at this level, descriptive and scientific. It is, as Boorse (1987: 379) suggests, indicative of organisms that are not performing their 'normal...function with at least statistically typical efficiency'. Thus, as the ICF (2001: 221) notes: 'impairment is a loss or abnormality of a body part (i.e. structure) or body...Abnormality here is used strictly to refer to a significant variation from established statistical norms (i.e. as a deviation from a population mean within measured standard norms) *and should be used only in this sense*' (emphasis added).

While the ICF notes that social and institutional relations (i.e. the interaction of body functions and structures with other domains) influence the meaning and consequences of impairment, the biological body, for the ICF, is 'a fact', and impairment, at the level of body functions and structures, is seen as a 'pre-social', biological, bodily difference. Such views are derived from a materialist ontology of the body, whereby the body is

conceived of as an entity with specific anatomical and genetic characteristics which exist independently of scientific discourses about it (Thomas, 1998: 7). Biology matters, but not in any simple, deterministic, sense, or where the understanding of the body is reduced to a fixed, transhistorical, category. Rather, the materialist ontology of the ICF conceives of the human body (and impairment) as a physical entity that delimits and defines, in part, the boundaries and capacities of human action. For Bury (1997: 198, quoting Harré, 1991: 3), this signifies that the body is no less than the 'material vehicle of person hood'.

This conception of impairment and the body is, however, not without its detractors. Thus, some regard the biological body per se as a social construction, or something that can never be known about outside of particular social discourses or modes of inquiry (into the body) (Grosz, 1994). For instance, as Thomas (1998: 8) suggests, 'determining which features of the body or intellectual functioning come to be defined as different from the 'usual' in any time or place is a social question and how these come to be named 'impairments' and medically defined abnormalities involves social processes and practices'. Such views, which stem from a post-structuralist perspective of society, reject any notion, such as that held by the ICF, that there is an essential (biological) body that can be said to be normal (Grosz, 1994). Indeed, the category 'normal', as intimated, is understood to be a social construction or something which itself needs to be explained. As Shildrick (1996: 176) notes: 'the body is materialised through discourse as both word

and practice...both our sense of our bodies and our selves, cannot be understood by reference to any fixed or essential bodily core'.

Such concerns have some merit in pointing towards possible slippage into reductionist conceptions of impairment. Thus, social constructivists note that 'natural' facts about disabled people, in the form of claims about biology, might be used to confer unequal treatment on disabled people or to justify prejudicial behaviour (Grosz, 1994). Others suggest that the positing of an essential body, which is categorised as 'normal', serves only to stigmatise the impaired body as 'not normal' or as deviant and deficient (Abberley, 1987, Hahn, 1986). Thus, some claim that documents, like the ICF, perpetuate a medical understanding of disability by constructing the disabled body as abnormal (because of biological differences) (Pfeiffer, 2000). For Oliver (1990), for example, the issue is not one of recognising the materiality of (biological) impairment and its determinate effects on functioning and health, but, rather, of asking how the impaired body is produced by the social and cultural practices of society.

To pose this question is, however, to (re) assert the duality between the biological and socio-cultural constructed body, something that the ICF is keen to avoid. If anything, the ICF ought to be, in my opinion, bolder and more explicit about its ontological claims (about the body and impairment), in order to provide the basis for a defence against viewpoints that are dismissive of the potency of the biological body in enframing life experiences (see Benton, 1991, Bickenbach, et al, 1999, Bury, 1997). Far from espousing a

form of biologism, as some social constructivist suggest, the ICF appears to be based on a 'realist' perspective of impairment, although it ought to be more explicit about such foundationalist roots (Benton, 1991). For Bury (1997: 192), this perspective is one whereby 'bodily contingencies', such as pain, are 'more than simply social constructions'. Rather, biology, and the materiality of the body, are an ever present, and interactive, dimension of social life, in which, as Kelly and Field (1996: 247) suggest, 'coping with the physical body has to precede coping with relationships'.

These views reflect the broader concern with what Bury (1997: 199) refers to as 'corporeal realities', or of how the biological body (in its manifest complexity) influences the content of functioning and health. As Kelly and Field (1996) suggest, the (biological) body never ceases to matter in social existence. It imposes (corporeal) conditions on (bodily) capabilities and capacities, yet, as Benton (1991: 5; quoted in Bury, 1997: 199) notes, it is also important to think about people 'who are necessarily organically embodied, but who also have psychological and social relational attributes'. This, then, is a position which reflects the ICF's materialist ontology or one whereby functioning and health is, first and foremost, understood as comprising a biological substrata overlaid with socially constructed ideas about the body.

(b). Specifying the content of biopsychosocial theory

As Bickenbach, et al (1999: 1183), note, the ICF 'embodies what is now termed the biopsychosocial model, a synthesis of the medical and social approaches to disablement'. This synthesis is a response to the over-medicalisation of the ICIDH and the tendency for the social model to detach 'disablement from its biomedical foundations' (Bickenbach, et al, 1999: 1183). Biopsychosocial theory (hereafter BPS) seeks to interconnect sociological enquiry with the biological sciences as a basis for developing a relational or non-dualistic understanding of the body. The determinants of functioning and health of individuals, for BPS, is conceived of as the composite of biology, personal or psychological, and social factors. In particular, BPS views the health of any population in its physical, mental, and social environments. Accordingly, BPS would reject manoeuvres to reduce an understanding of functioning and health to any one of its three core components.

However, like its definition and discussion of impairment, it is my contention that the ICF does not say much about the theoretical origins, or content, of BPS, except in the barest of details. It also provides limited justification for the adoption of BPS as the conceptual basis of the ICF. This, then, creates potential difficulties, for policy makers, medical practitioners, and academic commentators alike, in making judgements about the relevance (or not) of BPS in contributing to the understanding of functioning, disability, and health. In seeking to flesh out the nature of BPS, it would appear that its intellectual roots are in the psychiatric sciences (Dilts, 2001, Sarafino, 1994). As

Armstrong (1987) suggests, the development of BPS was primarily a response to the malaise of psychiatry that, in the late 1960's, was being simultaneously pulled either towards a biological reductionist view of mental illness, or approaches which stressed the role of social, or non-biological, factors in influencing mental health. The overtones with disability theory are evident.

In particular, BPS was, as Engel's (1977: 134) notes, a way of resolving 'a growing uneasiness among the public...that health needs are not being met and that biomedical research is not having a sufficient impact in human terms'. Thus, public disquiet with medical knowledge and procedures, and the inability for medicine to address psychosocial dimensions, were also important stimuli in the development of BPS (Bury, 1997). As Engels (1977: 131) suggests, BPS was the means to integrate medicine into a holistic framework 'to include the psychosocial without sacrificing the enormous advantages of the biomedical approach'. Likewise, the ICIDH was cast within a medicentric view of disability that, as Bickenbach, et al (1999: 1176) note, was, at best, 'a tool for research, administrative and planning uses by medical professionals'. This, then, limited the ICIDH's effectiveness in failing 'to provide a flexible tool for research and data collection on all aspects of disablement' (Bickenbach, 1999: 1187).

The ICF's (2001: 20) adoption of BPS is one that seeks to 'achieve a synthesis thereby providing a coherent view of different dimensions of health at biological, individual and social levels'. However, little is said about how the synthesis will achieve this 'coherent

view', while the ICF is relatively silent, except in the most general of terms, about the relevance of BPS to the development of disability theory. Rather, it is assumed that BPS is a natural steer, or middle way, through the divergent discourses of disability. Others also note that BPS is no more than a 'a new medical model' or, as Day (1985: 1355) suggests, 'the BPS approach is the study of biological paradigms within social parameters'. Moreover, there is little evidence of the development or application of BPS theory outside of the biological and psychiatric sciences (Dilts, 2001). This, for some, implies, potentially, 'a strengthening of traditional biological, reductionist medicine' while maintaining the 'subsidiary status of the social sciences' (Armstrong, 1987: 1213; also, see Fougetrollas and Beauregard, 2001).

These observations raise pertinent and relevant concerns, not the least of which is the nature and adequacy of BPS's conception of social structure and process. While the ICF does not identify the intellectual origins of BPS, it is derived from structural functionalism, or a conception of society which, as figure 1 suggests, exists on different and distinct levels of organisation (Parsons, 1951). Society comprises 'interlocking systems' in which the four domains of the physiological, personality, social, and cultural are seen to operate at one level of a more general hierarchy of interrelated levels (Armstrong, 1987: 1213). For Parsons (1951), society is analogous to an organic system, or one whereby particular (bodily) needs have to be met in order to maintain the stasis of the system. Thus, while organisms require food and water for their reproduction, social

systems also have needs 'that must be serviced in order to remain properly operational' (Layder, 1994: 18).

Figure 1 here

As Parsons (1951) notes, the body is the foundational level of the social system, in the sense that it is a container for the impulses, desires, and motivations that comprises individuals' personalities and related actions. However, for Parsons (1951), the nature of personality and action is not to be understood wholly in terms of organic or biological processes; rather, it has its own emergent properties. These are tied to interactions between individuals or where, as Layder (1994: 17) notes, social systems emerge 'from interactions which are repeated over time and which produce durable expectations about the behaviour of those involved'. In turn, such (systems) interactions and expectations are part of the core values and normative elements of society, that is, the cultural system or what Layder (1994: 18) refers to as 'the sedimentation of values and tradition'.

While a fuller description and evaluation of structural functionalism is beyond the scope of this paper, it is likely that the ICF will replicate some of the weaknesses associated with the systems conception of society. These have been well highlighted elsewhere but, in brief, include observations that there is an over-emphasis on systems harmony, interaction, and consensus, and less recognition of systems rupture, tension, and conflict. Similarly, others suggest that debates about social inequality and issues of

difference are less likely to surface given the emphasis on systems harmony. However, such views are contested by those who recognise that structural functionalism refers to the 'layered nature' of society, or where everything is interrelated and mutually dependent. This, then, is a conception of society, and social processes, which is core to the ICF; in Layder's (1994: 33) terms, 'society is made up of elements of fundamentally different kinds, but which are completely and inescapably linked to each other'.

For some, however, the systems linkages between the ICF's main elements, of the body, activity, and participation, require further clarification. As Fougeyrollas and Beauregard (2001: 186) note, the integrative nature of the domains may be far from apparent to potential users. As they suggest, 'far from being integrated, the three domains can be used independently, and the body and activity ones will be well accepted by biomedical, compensation, and programme eligibility gatekeepers'. Others note that further clarification of the integrative nature of BPS is required. Thus, as Armstrong (1987: 1214) comments, 'disciplines at different levels of the systems hierarchy might have different and conflicting explanations of the same phenomenon but rather than one explanation being in a position to challenge another they are reduced to simply different levels of analysis'. Indeed, it is important that BPS is more than just the addition of one perspective to another or differentiating between them. This runs the risk of maintaining a conceptual separation, or where debate will never move beyond arguments about which perspective is more important and therefore more powerful than the other.

(c). The universal nature of disability

The WHO (2001: 7) has commented that 'there is a widely held misunderstanding that the ICF is only about people with disabilities; in fact, it is about all people...in other words, the ICF has universal application'. The ICF's claim to universal application is amplified by Bickenbach, et al (1999), who note that the document is based on Irving Zola's (1989) concept of universalisation, and his related calls for universal policies towards meeting the needs of disabled people. As Zola (1989: 401) suggested, 'an exclusively special needs approach to disability is inevitably a short run approach. What we need are more universal policies'. This sets the tenor and direction for the ICF or, as Bickenbach, et al, (1999: 1184) suggest, the ICF 'from the ground up, embodies the principle of universalism'.

While the ICF's commitment to universalism is laudable and worthwhile, it does not really discuss nor justify its adoption or use of universal principles of disability (although, see Bickenbach, et al, 1999). This is, perhaps, not surprising given that, as Bickenbach, et al (1999: 1183) note, 'Zola's proposals for a universalistic disablement policy were tentative and have yet to be spelled out in any detail'. For the ICF, however, universalism is based on the recognition that the population as a whole is at risk from acquiring impairment and chronic illness. Thus, as Turner (2001: 263) suggests, 'frailty is a universal condition of the human species because pain is a fundamental experience of all organic life'. Others concur by suggesting that the natural life course, or ageing, will

inevitably increase the proportion of people with impairments and chronic health conditions (Bury, 1997). For Bickenbach, et al, (1999: 1181), a universal disability policy seeks to demystify the 'specialness' of disability by recognising 'that all people have needs that vary in roughly predictable ways over the course of their life span'.

However, the claim has the potential to counterpoise two positions, as though they were opposites, and, in doing so, to discount the suggestion that a universal approach to policy need not, necessarily, preclude some sensitivity to the nature of, and needs generated by, particular types of impairments. Thus, the problem here is that the ICF is in danger of replicating debates that, unjustifiably, counterpoise the universal with the particular (Thompson and Hoggett, 1996, Williams, 1992). Indeed, this observation is a central strand of Zola's concept of universalisation that does not deny the significance of specific or special needs or demands of people with particular types of impairment. As Zola (1989: 420) suggests, the recognition of the "near universality of disability" ought to be part of "an additional complementary strategy". For Zola (1989: 422), this entails the development of "a concept of special needs which is not based on breaking the rules of order for the few but on designing a flexible world for the many". Thus, Zola never discounted the relevance of special needs, nor denied the efficacy of a minority group conception of disability.

Proponents of the ICF are not unaware of Zola's observations and, as Bickenbach, et al (1999: 1183) note, universal policies are based on responding to 'empirically-grounded

human variation'. In particular, Bickenbach, et al, (1999: 1185) indicate that the ICF's support for universalism is not, then, to deny that 'the personal and social burdens of disability are unevenly distributed'. This recognition, after Zola, provides potential for linking the universal to the particular, or the understanding that universalism need not just support uniform treatment, but 'can show sensitivity to certain sorts of differences' (Thompson and Hoggett, 1996: 30). Thompson and Hoggett (1996), who suggest that the choice of either universalism or particularism is misconceived, develop such observations. As they suggest, 'any justifiable universalism, or egalitarianism must take particularity and difference into account: and any legitimate particularism or politics of difference must employ some universal or egalitarian standard' (Thompson and Hoggett, 1996: 23).

These debates are well developed in the disciplines of sociology and social policy, and it is not unreasonable for the ICF, and commentators about it, to flesh them out to enable the development of appropriate, universalistic, principles of disablement (Titmuss, 1976). While this is a major task, and beyond the scope of this paper, some suggestions can be made. One possible starting point is the scepticism that some express about universal claims concerning human existence. In particular, some observers note that universal (welfare) policies are unable to take into account the wide variety of particular human situations and end up by projecting specific, individual, values onto society as a whole. Thus, as feminist scholars note, universalism tends to be particularistic in prioritising the (moral) interests of men rather than women (Williams, 1992). Disability

scholars argue likewise in noting that universal principles are likely to favour dominant groups or, at least, assert the normality and morality of able-bodied people (Corker, 1998).

However, the reality, as Thompson and Hoggett (1996) acknowledge, is that universal policies cannot ignore social diversity, or political pressures to provide selective benefits and services, as social rights, to particular categories of disabled people or groups. For Thompson and Hoggett (1996: 33), 'the very point of universalism is to establish an impartial standard between *different* persons and groups'. Indeed, difference is at the heart of universalism, in the sense that the underlying value base is one of toleration, or of providing the socio-institutional frameworks for groups to co-exist. Thus, selective or special programmes are not necessarily contrary to universal principles. Rather, they tend to reflect a commitment to universal equalitarianism, although, as commentators note, ensuing policy programmes often fail to achieve their goals and sometimes do little more than to stigmatise and mark groups out, something the ICF is keen to avoid (Titmuss, 1976).

This failure, so some argue, is because of the absence of a *particularistic* emphasis in the development of (universal) policy programmes. This emphasis, in one sense, is not dissimilar to a selectivist approach to policy by responding to the 'particular needs, moral frameworks and social expectations of different groups' (Thompson and Hoggett, 1996: 31). However, particularism differs in its objective of developing programmes that

are, allegedly, sensitised to groups' self perceptions of their situation. The distinguishing feature is, for Thompson and Hoggett (1996: 32), one that, potentially, provides groups with opportunities 'to determine the conditions of their own lives'. Such opportunities are based on (policy makers) seeking to understanding what groups' value, require, and need, and of responding to their moral frameworks and social expectations. Thus, different standards are seen as appropriate in different circumstances for different groups or individuals (Titmuss, 1976).

A particularistic emphasis in disability policy need not be contrary to the pursuit of universal principles. In seeking to respond to local (not universal) contexts, particularism is based on the idea that principles of justice ought to reflect local values. This claim, though, is based on a universal principle (i.e. justice should reflect local values) (also, see Thompson and Hoggett, 1996). Likewise, feminist criticisms of universalism are based on a universal principle, or the principle that differences between people ought to be the basis for mutual respect. Thus, as Thompson and Hoggett (1996: 35) conclude, 'any universalism that makes serious attempts to be sensitive to the differences between particular cases, and particularism with the moral force to adjudicate between differences, are in fact the same theories looked at from opposite points of view'. In these, and related, senses, particularism and universalism are not necessarily mutually exclusive and, in combination, may well provide a way of developing some of the insights of Irving Zola.

(4). Conclusions

The publication of the ICF is an important moment in the (re) conceptualisation of the nature of disability. It represents a reaction to the impasse of debates couched around either accepting a medical or a social account of the determinants of disability (also, see Edwards and Imrie, 2002). In contrast, far from reducing the understanding of disability to either physiology or social and attitudinal barriers, the ICF seeks to develop a relational understanding of the determinants of disability. This emphasises the interplay between the body, the person, and broader social and environmental factors in determining the content of disability. In doing so, the ICF is noting that any understanding of functioning and health has to incorporate insights from both sociological and biological enquiry. This represents the ICF's commitment to a pluralist and consensual approach to theory building, or one which seeks to cross the divides and differences between disciplines that, in combination, have much to offer to an understanding of human functioning and health.

However, the core claim, and contribution, of this paper is the observation that the ICF is conceptually underdeveloped, in the sense that it fails to specify or evaluate, in any detail, the nature and adequacy of some of its theoretical underpinnings. For instance, BPS is at the heart of the ICF yet little is known about its conceptual origins, or of its operational or practical utility. As the paper suggests, given that its connections are with (in)

biomedicine and structural functionalist social theory, how far does this provide an adequate (middle-way) theoretical foundation for an understanding of the determinants of functioning and health? For instance, it is possible, although by no means certain, that the biomedical origins of BPS may well lead back to the entrapment of reductive conceptions of disability and impairment, that is that the biological is prior to the social. It is not sufficient for the ICF to say that the latter is a problematical formulation; it requires it to deploy and develop, in detail, the theoretical basis to ensure that such formulations are avoided (as the basis of coherent disability policies and programmes).

Likewise, the ICF's (political) commitment to universalism is based on a threadbare description of the underlying principles. Universalism, as an idea, is multi-faceted and contested by many different shades of opinion, and the ICF falls short in providing few details about the particular brand, or variant, of universalism it is seeking to subscribe to (although, see Bickenbach, et al, 1999). It is, therefore, incumbent on scholars of the sociology of medicine and illness, and others, to contribute to the further development of these, and related, aspects of the ICF, in order to add value to a document which is, already, a basis for a much more sensitised understanding of the determinants of functioning and health.

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Footnotes

(1). The term discourse is used in a variety of ways. I understand it to mean a system of concepts that create knowledge about objects and/or people.

(2). Sociological critiques of biomedical discourses of disability are ahistorical in their presentation of negative and caricatured views of biomedicine (see Williams, 2001). As Kelly and Field (1994: 35) suggest, it is 'actually very hard to find this medical model in practice. Few practitioners and no textbooks of any repute subscribe to uni-directional causal models and invariably interventions are seen in medical practice as contingent and multi-factorial'.

Figure 1: Systems levels in structural functionalist theory

System or level	Aspect of experience
1. The physiological system	The body
2. The personality system	Individual psychology
3. The social system	Roles and positions
4. The cultural system	Knowledge, literature, art, and other human products

Source: Layder, 1994: 15

References

- Abberley, P. (1987) The concept of oppression and the development of a social theory of disability, **Disability, Handicap, and Society**, **2**, **1**, 5-19.
- Anderson, E. and Clarke, L. (1982) **Disability and Adolescence**, London: Methuen.
- Armstrong, D. (1987) Theoretical tensions in biopsychosocial medicine, **Social Science and Medicine**, **25**, **11**, 1213-1218.
- Bauman, Z. (1992) **Mortality, Immortality and Other Life Strategies**, Cambridge: Polity Press.
- Benton, T. (1991) Biology and social science: why the return of the repressed should be given a (cautious) welcome, **Sociology**, **25**, **1**, 1-29.
- Bickenbach, J. (1993) **Physical Disability and Social Policy**, Toronto: University of Toronto Press.
- Bickenbach, J., Chatterji, S., Badley, E., and Ustun, T., (1999) Models of disablement, universalism and the international classification of impairments, disabilities and handicaps, **Social Science and Medicine**, **48**, 1173-1187.
- Blaxter, M. (1980) **The Meaning of Disability**, London: Heinemann.
- Boorse, C. (1987) Concepts of health, in VanDeveer, D. and Regan, T. (eds.), **Health Care Ethics: An Introduction**, Philadelphia: Temple University Press, 359-393.
- Brisenden, S. (1998) Independent living and the medical model, in Shakespeare, T., (ed.), **The Disability Reader: Social Science Perspectives**, London: Cassell, 20-27.
- Bury, M. (1997) **Health and illness in a changing society**, London: Routledge.
- Bury, M. (2000) A comment on the ICDH2, **Disability and Society**, **15**, **7**, 1073-1078.
- Butler, J. (1993) **Bodies that matter: on the discursive limits of sex**, London: Routledge.
- Corker, M. (1998) **Deaf and disabled or deafness disabled?** Milton Keynes: Open University Press.
- Crow, L. (1996) Including all of our lives: renewing the social model of disability, in Morris, J., (ed.), **Encounters with Strangers**, London: Women's Press, 55-73.

- Day, S. (1985) The advance to biopsychosocial medicine, **Social Science and Medicine**, **21**, 1335-
- Dilts, S. (2001) **Models of the mind: a framework for biopsychosocial psychiatry**, London: Routledge.
- Edwards, C. and Imrie, R., 2003, Disability and bodies as bearers of value, **Sociology**, **37**, **2**, 239-256.
- Elias, N. (1991) **The Symbol Theory**, London: Sage.
- Engel, G. (1977) The need for a new medical model: a challenge for biomedicine, **Science**, **196**, 129.
- Fine, M. and Asch, A. (1988) **Women with Disabilities**, Philadelphia: Temple University Press.
- Fougeyrollas, P. and Beauregard, L. (2001) Disability: an interactive person-environment social creation, in **Handbook of Disability Studies**, London: Sage, , 171-194.
- Goffman, E. (1963) **Stigma: notes on the management of a spoiled identity**, New York: Simon and Schuster.
- Grosz, E. (1994) **Volatile bodies: towards a corporeal feminism**, Bloomington: Indiana University Press.
- Hahn, H. (1986) Public support for rehabilitation programs: the analysis of US Disability Policy, **Disability, Handicap, and Society**, **1**, **2**, 121-138.
- Harré, R. (1991) **Physical Being: A Theory for a Corporeal Psychology**, Oxford: Blackwell.
- Hughes, B and Paterson, K.. (1997) The social model of disability and the disappearing body: towards a sociology of impairment, **Disability and Society**, **12**, **3**, 325-340.
- Hurst, R. (2000) To revise or not to revise, **Disability and Society**, **15**, **7**, 1083-1087.
- Imrie, R. (2000) Disability and discourses of mobility and movement, **Environment and Planning A**, **32**, 1641-1656.
- Kasprzyk, D. (1983) Psychological factors associated with response to hypertension or spinal cord injury: an investigation of coping with chronic illness or disability, **Dissertations Abstracts International**, **44**, **4b**, 1279.

- Kelly, M. and Field, D. (1994) Comments on the rejection of the biomedical model in sociological discourse, **Medical Sociology News**, **19**, **3**, 34-37.
- Kelly, M. and Field, D. (1996) Medical sociology, chronic illness and the body, **Sociology of Health and Illness**, **18**, **2**, 241-257.
- Layder, D. (1994) **Understanding Social Theory**, London: Sage.
- Marks, D. (1999) **Disability: controversial debates and psychosocial perspectives**, London: Routledge.
- Morgan, M. (1996) The meaning of high blood pressure among Afro-Caribbean and white patients, in Kelleher, D. and Hillier, S. (eds.), **Researching Cultural Differences in Health**, London: Routledge.
- Nettleton, S. (1995) **The Sociology of Health and Illness**, Oxford: Polity.
- Oliver, M. (1990) **The Politics of Disablement**, London: MacMillan.
- OPCS (1993) **The United Kingdom Census Office of Population Censuses and Surveys**, London: HMSO.
- Parson, T. (1951) **The Social System**, London: Routledge.
- Paterson, K. and Hughes, B. (1999) Disability studies and phenomenology: the carnal politics of everyday life, **Disability and Society**, **14**, **5**, 597-611.
- Pfeiffer, D. (1998) The ICIDH and the need for its revision, **Disability and Society**, **13**, **4**, 503-523.
- Pfeiffer, D. (2000) The devils are in the details: the ICIDH2 and the disability movement, **Disability and Society**, **15**, **7**, 1079-1082.
- Rhodes, D. (1985) **An outline of history medicine**, London: Butterworth.
- Safilos-Rothschild, C. (1970) **The Sociology and Social Psychology of Disability and Rehabilitation**, New York: Random House.
- Sarafino, E. (1994) **Health Psychology: biopsychosocial interactions**, London: Wiley.
- Shildrick, M., (1996) **Leaky Bodies and Boundaries: Feminism, Post-modernism, and (Bio) Ethics**, London: Routledge.

Shilling, C. (1993) **The Body and Social Theory**, London: Sage.

Thomas, C. (1998) The body and society: some reflections on the concepts 'disability' and 'impairment', **British Sociological Association paper**, Edinburgh, April.

Thompson, S. and Hoggett, P. (1996) Universalism, selectivism and particularism: towards a postmodern social policy, **Critical Social Policy**, **16**, 21-43.

Titmuss, R. (1976) **Commitment to Welfare**, London: Allen and Unwin.

Turner, B. (2001) Disability and the sociology of the body, in Albrechts, G., Seelman, K. and Bury, M., (eds.), **Handbook of Disability Studies**, London: Sage, 252-266.

Wiener, C. (1975) The burden of rheumatoid arthritis: tolerating the uncertainty, **Social Science and Medicine**, **9**, 97-104.

Williams, F. (1992) Somewhere over the rainbow: universality and diversity in social policy, **Social Policy Review**, **4**,

Williams, S. (1999) Is anybody there? Critical realism, chronic illness, and the disability debate, **Sociology of Health and Illness**, **21**, **6**, 797-819.

Williams, S. (2001) Sociological imperialism and the profession of medicine revisited: where are we now?, **Sociology of Health and Illness**, **23**, **2**, 135-158.

World Health Organisation (1980) **The International Classification of Impairments, Disabilities, and Handicaps**, Geneva: WHO.

World Health Organisation (2001) **International Classification of Functioning, Disability and Health**, Geneva: WHO.

Zola, I. (1972) Medicine as an institution of social control, **Sociological Review** **20**, 487-504.

Zola, I. (1989) Towards the necessary universalising of a disability policy, **The Milbank Quarterly**, **67**, **2**, 401-428.