

How Does Pain Fit into the Social Model of Disability?

Sophia Decherney

Introduction

The Social Model of Disability, though its conception varies across theorists, claims that people are disabled not only by impairment and difference, but also, by the barriers constructed by society. However, theorists such as Elizabeth Barnes and Susan Wendell believe pain poses a special problem for social theorists. Insofar as pain, even with the absence of social barriers, detracts from an individual's quality of life. If so, Social Model theorists are left to evaluate: is it possible to fit pain into the Social Model of Disability? And, if so, would it be a worthwhile pursuit?

In this paper, I first describe how the Social Model departs from the previously accepted medical model of disability. I then explore several critiques of the Social Model that show how it fails to incorporate the experience of chronic pain sufficiently. I present three strategies with which the Social Model responds to those critiques: breaking away from a literal interpretation of the model, distinguishing chronic pain from other forms of disability, and considering how the experience of pain might be alleviated through the removal of societal barriers. Lastly, I investigate the usefulness of the Social Model for conceptualizing pain by applying it to the controversial case of assisted suicide. I conclude that the Social Model of Disability is a useful tool for theorizing chronic pain because it offers important objections to the idea that assisted suicide offers autonomy and choice to a chronic pain experiencer. In the final analysis, I demonstrate that although the Social Model has theoretical difficulties in modeling pain, the case study of assisted suicide offers good reasons to work through those difficulties.

What is the Social Model of Disability?

The goal is to assess the efficacy of the Social Model of Disability for chronic pain experiencers through evaluating the ethics of assisted suicide. However, to do so, one must first understand what adherents to that model believe about health and disability. Developed in the 1970s, the Social Model of Disability emerged in opposition to the medical model, which views health and disability through the lens of the natural sciences. The medical model, which defines disability as “independent

of our specific, contingent social categories and practices . . . social or personal values,” is based on “statistical normalcy, adaptive fitness, and biological function.”¹ By contrast, the Social Model defines disability through a barriers-based approach, which considers the environmental, social, cultural, and political factors that impede and, in doing so, disable non-normative bodies.² Unlike the medical model, which emphasizes individual impairment in defining disability, the Social Model is societal in scope. Its theorists contend that “disability definitions are not rationally determined but socially constructed” by the “social meanings individuals attach to particular physical and mental impairments.”³

Many Social Model theorists take the stance that disability and impairment are constituted by societal barriers, and since “barriers can be removed [and] if you remove the barrier then you [can] remove the disability.”⁴ Whereas medical model theorists believe that “difficulties faced by disabled people are a direct result of their individual impairments or lack or loss of functioning,” Social Model theorists contend that disability is created by a society built for non-disabled people. Accordingly, disability can be defined as a type of “social oppression.”⁵ Thus, proponents of the Social Model claim that a reconstruction of society to fit disabled and chronically ill individuals will lift this social oppression and, if not eliminating disability entirely, will at least eliminate the need for the category of disability.⁶ However, critics of the Social Model object that it does not fit all disabilities, including, but not limited to, chronic pain.

Critique of the Social Model: No Room for Pain

One major critique of the Social Model of Disability is its failure to address the issue of pain. In a literal reading of the barriers-based approach, if the removal of barriers leads to the removal of disability, then removing barriers should also eliminate pain from someone living with chronic pain. However, it seems unlikely that the dismantling of societal barriers could totally eliminate the experience of pain for persons with chronic

1 Quill Kukla, “Medicalization, ‘Normal Function,’ and the Definition of Health,” in *The Routledge Companion to Bioethics*, eds. John D. Arras, Elizabeth Fenton, and Quill Kukla, 1st ed. (Routledge, 2014), 515–16.

2 Tom Shakespeare, “The Social Model of Disability,” in *The Disability Studies Reader*, ed. Lennard J. Davis, 2nd ed. (Routledge, 2006), 197.

3 Gary L. Albrecht and Judith A. Levy, “Constructing Disabilities as Social Problems,” in *Cross National Rehabilitation Policies: A Sociological Perspective*, ed. Gary L. Albrecht (Sage Publications, 1981), 14. This paper evaluates the usefulness of the definition provided by the Social Model of disability and so mentions of “disability” going forward can be assumed to take on the Social Model definition.

4 “The Social Model of Disability,” Welsh Government Services and Information, accessed April 27, 2024, <https://www.gov.wales/sites/default/files/publications/2023-06/atish17524doc7.pdf>.

5 Sally French and John Swain, “Changing Relationships for Promoting Health,” in *Tidy's Physiotherapy*, ed. Stuart Porter, 15th ed. (Churchill Livingstone, 2013), 190.

6 Michael Oliver, *The Politics of Disablement: Critical Texts in Social Work and the Welfare State* (Palgrave, 1990), 78–81.

pain.⁷ Cara Jones raises this critique of Social Model in her article “The Pain of Endo Existence: Toward a Feminist Disability Studies Reading of Endometriosis” (2016). She points out that while one symptom of endometriosis, infertility, is widely addressed by Social Model theorists, another symptom of endometriosis, chronic pain, is “largely under-theorized” precisely because it is harder to explain by a barriers approach.⁸ Society might no longer consider infertility disabling if it ceased to value fertility as a norm of the female experience (after all, men who are unable to carry a pregnancy are not considered disabled); by comparison, a life devoid of pain seems less like a socially constructed value than it does a universal good.

Emily Rogers offers a similar critique in her article “Recursive Debility,” which follows a patient activist group that fought to have their painful condition identified as a chronic illness (ME/CFS). Rogers argues that it is necessary to recognize bodily impairment, such as pain, alongside socio-political aspects of disability in order to understand the interdependent facets of the disabled/chronically ill experience which a purely Social Model of Disability might obscure.⁹ Indeed, critics of the Social Model caution that when it comes to impairments such as pain, Social Model theorists “are in danger of assuming that impairment has no part at all in determining our experiences.”¹⁰ Even critics who acknowledge that social factors play a large part in the destabilization of people living with chronic pain argue that the Social Model offers too simplistic an explanation by presenting impairment as “irrelevant, neutral and, sometimes, positive, but never, ever as the quandary it really is.”¹¹ In fact, by conceptualizing disability as a condition caused primarily by societal factors and by including only those disabilities clearly delimited by social barriers, the Social Model risks excluding painful conditions entirely.¹²

Theories of Pain Under the Social Model

Studies tackling the issue of how to incorporate chronic and acute pain into the Social Model framework can be categorized into three major approaches. All three address the problematic notion that removing social barriers should eradicate pain. The first approach argues that the removal of barriers will eradicate not disability in a literal sense

7 Liz Crow, “Including All of Our Lives: Renewing the Social Model of Disability,” in *Equality, Participation, and Inclusion: Diverse Perspectives*, eds. Jonathan Rix, Melanie Nind, Kieron Sheehy, Katy Simmons, and Christopher Walsh, 2nd ed. (Routledge, 2010), 134–37.

8 Cara Jones, “The Pain of Endo Existence: Toward a Feminist Disability Studies Reading of Endometriosis,” *Hypatia* 31, no. 3 (2016): 55, <https://www.jstor.org/stable/44076492>. Endometriosis is a uterine condition with symptoms including painful periods and infertility.

9 Emily Lim Rogers, “Recursive Debility: Symptoms, Patient Activism, and the Incomplete Medicalization of ME/CFS,” *Medical Anthropology Quarterly* 36, no. 3 (2022): 412, <https://doi.org/10.1111/maq.12701>.

10 Crow, “Including All Our Lives,” 126.

11 Crow, “Including All Our Lives,” 126.

12 Crow, “Including All Our Lives,” 136.

but rather the need to specify disability as a discrete category of the human condition. A second approach separates chronic pain from other disabilities by creating a special framework for impairments or unhealthy disabilities.¹³ A third approach contends that the removal of social barriers will actually diminish and, in extreme cases, totally eradicate the experience of pain.

Approach One: Breaking Away from the Literal Sense

This first approach to the problem of pain in the Social Model of Disability asserts that, when it comes to pain, the removal of barriers should not be taken literally.¹⁴ Indeed, as some Social Model theorists suggest, the removal of barriers can be expected to eradicate not the physical experience of pain but rather the disruption that chronic pain causes. It stands to reason, therefore, that society should dismantle the physical and ideological obstacles preventing chronic pain experiencers from participating fully in society. In doing so, it would not only reduce the limitations on those living with pain but also the need to categorize people who experience chronic pain.¹⁵

In his book *The Polio Paradox* (2002), for example, Dr. Richard Bruno suggests that it is not the experience of the sensation of pain that makes life difficult for those disabled by Post-Polio Syndrome (PPS) but rather a society that promotes norms incompatible with PPS existence.¹⁶ Such social factors also contribute to the underdiagnosis and undertreatment of PPS, by perpetuating, for instance, the cultural prejudice that young people—the most common age group affected at the time of his book—do not experience chronic pain but merely seek drugs.¹⁷ Moreover, according to Bruno, many other global (though by no means universal) social norms make chronic pain debilitating in our modern society: constantly working at the upper limits of one’s ability instead of at a sustainable level, using every available assistive device at all times, internalizing the idea that pain is necessary for advancement (no pain, no gain); overdoing rehabilitation exercises; and pushing through uncomfortable temperatures.¹⁸ If these practices were to be denormalized, he argues, PPS patients would continue to experience pain but would no longer be considered disabled.¹⁹ In this view, remodeling society’s values and practices neither cures pain nor does away with deviations from the “normal body”; instead, it accounts for these deviations, thereby abolishing the need for the category of disability. By suggesting problems with breaking away from the literal definition of disability, Bruno creates the preconditions for a unique consideration of pain within the social model.

Approach Two: Separating Out Chronic Pain from Other Disabilities

Susan Wendell, in her article “Unhealthy Disabled: Treating Chronic Illnesses as

13 Susan Wendell, “Unhealthy Disabled: Treating Chronic Illnesses as Disabilities,” *Hypatia* 16, no. 4 (2001): 25–28, <https://doi.org/10.11353/hyp.2001.0062>.

14 Elizabeth Barnes, “The Hysteria Accusation,” *Aeon*, June 20, 2020, <https://aeon.co/essays/womens-pain-it-seems-is-hysterical-until-proven-otherwise>.

15 Richard L. Bruno, *The Polio Paradox* (Grand Central Publishing, 2024), 5.

16 Bruno, *The Polio Paradox*, 3–5.

17 Bruno, *The Polio Paradox*, 32.

18 Bruno, *The Polio Paradox*, 36–40.

19 Bruno, *The Polio Paradox*, 51.

Disabilities” (2001) posits that there are actually two categories of disabled people who ought to be treated differently under the Social Model. The first is “healthy disabled” people who have impairments or normative deviations but are not actually “sick.” People in this category might include individuals who are deaf, autistic, or wheelchair-bound. Some characteristics of this type are that their disability does not lower their life expectancy and that their impairments are fairly static rather than deteriorating or fluctuating (although someone’s status as healthy disabled may change throughout their lifetime).²⁰ The Social Model deals well with situations such as these as removing the barrier removes the negative experiences of the disability, i.e., if everyone knew sign language, there would be few negative consequences of being deaf.

On the other hand, those with chronic pain fit into a group Wendell categorizes as “unhealthy disabled.”²¹ This category includes terminal conditions as well as any condition that would have a negative impact on the life of the individual even if society was built with them in mind. The Social Model is applied less effectively to this category because “impairment in itself can be a negative, painful experience.”²² Wendell cautions against applying the message “remove the barriers that have been erected arbitrarily against our participation, and we will perform as well as anyone else” to people in the unhealthy disabled category.²³ Instead, she claims that this aspect of the Social Model may only work for those in the category of healthy disability.²⁴ Thus, by separating the unhealthy and healthy disabled, she illustrates how a Social Model of Disability needs to be differently tailored to each of the two groups.²⁵

Approach Three: Literally Reducing the Pain Experience

A third group of Social Model theorists believe that removing barriers does, in fact, reduce or remove the physical experience of pain. In the weaker version of this view, societal barriers do not cause the physical sensation of pain as much as they contribute to the experience of that sensation as debilitating. For example, women, people of color, and younger people are far less likely to receive adequate care for pain. As a result, pain plays a larger role in their lives, and because they are inadequately treated, they experience far more debilitation and impairment from that pain in the long term.²⁶ Moreover, many societal factors cause or exacerbate pain, such as stress, hygiene, and access to consistent and comfortable sleeping conditions. If these barriers were to be removed, experiencers of pain would suffer less or may not experience pain in the first place.

In this theory, deconstructing the social barriers will not obliterate the experience of pain, but it will remove those factors that make pain worse and prevent pain experiencers from receiving adequate care.²⁷ It might also, in particular cases, prevent painful conditions

from developing in the first place, removing chronic pain entirely.²⁸ In a stronger iteration of this claim, some theorists go so far as to argue that removing social barriers would wholly abolish the sensory experience of pain. These theorists point out that although we currently have technology that can completely eliminate pain, prejudices regarding morally correct ways to experience pain prevent doctors from prioritizing pain mitigation in treatment plans.²⁹ Without promoting any one particular theory, I submit that the strong arguments outlined above indicate that there is potential for theorists to create a space for pain within the theoretical framework of the Social Model. However, the question remains whether there is a good reason to adopt the Social Model for pain.

Contributions of the Social Model to Pain: A Case Study of Assisted Suicide

One way to evaluate the usefulness of a Social Model of pain is by assessing its contributions to a major controversy within pain ethics: assisted suicide. Assisted suicide, physician-induced patient-consented euthanasia, has been on the rise across the world. Social Model theorists offer four main objections to assisted suicide for chronic pain experiencers: it represents an individualist vs. societal approach to the body, it misleadingly presents patients’ motivations for suicide, gives a false sense of choice, and, lastly, relies on cultural narratives that offer merely the illusion of agency as well as harmful moral ideas of what constitutes a good death.

Focus on the Individual Body

The Social Model of Disability argues that viewing pain as an individual misfortune rather than a condition impacted by political and societal conditions causes people to view chronic pain as a tragedy. According to some Social Model theorists, assisted suicide reinforces this tragic view of pain by suggesting that the death of a human in pain is better than their continued living experience of pain. By contrast, they argue that when barriers such as social isolation, impossible work expectations, etc., are successfully removed, a life of pain no longer means a life of suffering.³⁰ And yet, the rhetoric around assisted suicide reinforces the view that people in chronic pain would prefer death (more than they would prefer to have fulfilling jobs, equality, and higher standards of life, etc.) by portraying a life of pain as a tragedy worse than death. Ultimately, the option of assisted suicide prevents society from taking steps to alleviate pain and improve the quality of life. Proponents of this idea posit that if pain were seen as a societal rather than individual problem, as the Social Model suggests, then a person in pain who requests death would signal the failure of society to support that person, not an individual tragedy.³¹

Questioning Motivations: Is Pain Really the Problem?

While physicians and ethicists cite the unbearable suffering of chronic pain as a

20 Wendell, “Unhealthy Disabled,” 19.

21 Wendell, “Unhealthy Disabled,” 18.

22 Crow, “Including All Our Lives,” 134.

23 Wendell, “Unhealthy Disabled,” 27.

24 Wendell, “Unhealthy Disabled,” 28.

25 Wendell, “Unhealthy Disabled,” 30–32.

26 Barnes, “The Hysteria Accusation.”

27 Barnes, “The Hysteria Accusation.”

28 Barnes, “The Hysteria Accusation.”

29 Felicia Nimue Ackerman, “‘I Support the Right to Die. You Go First’: Bias and Physician-Assisted Suicide,” in *Palgrave Handbook of Philosophy and Public Policy*, ed. David Boonin (Palgrave Macmillan, 2018).

30 Understanding suffering as a lowered quality of life.

31 Martha Stoddard Holmes, “Pain,” in *Keywords for Disability Studies*, eds. Rachel Adams, Benjamin Reiss, and David Serlin (New York University Press, 2015), 133–34.

primary justification for assisted suicide, the social modeling of assisted suicide reveals a more complex set of rationales for chronic pain experiencers who seek death. In fact, according to the data, pain is not a top consideration in requests for assisted suicide by people with chronic pain. Rather, they cite social isolation and economic dependency/poverty, both societal-level barriers.³² Additionally, there is no objective experience of pain that physicians can reference when determining the quality of life of a chronic pain experiencer, so there is no objective way to link a pain level to decreased quality of life.³³

The assumption that living with pain is inevitably much worse than living a “normal” life overestimates the difficulty faced by people with impairments, and incorrectly identifies pain as the main cause of their difficulties. Indeed, patient reports show that when political, economic, and societal barriers are removed, the self-reported quality of life of a chronic pain experiencer falls well within the normal range of people without chronic pain.³⁴ In summation, by legalizing euthanasia for those experiencing chronic pain on the basis of their quality of life, physicians and lawmakers miss the larger societal issues contributing to the poor quality of life of disabled individuals. A

False Choices and Illusions of Agency

Another way that the Social Model can be evaluated is in its ability to counter normative arguments in favor of assisted suicide for pain experiencers. A contested argument for assisted suicide as an option for chronic pain experiencers is that it affords autonomy through choice.³⁵ Social Model theorists counter this argument by pointing out ways in which societal factors make assisted suicide a non-autonomous choice. For example, the lack of high-quality end-of-life care for those without the means to afford expensive private hospital treatment creates an environment for pain experiences in which death is indeed preferable.³⁶ Similarly, there is persuasive evidence that the pervasive cultural narrative about a life of pain—namely, that it is unbearable—affects the brain’s neuroplasticity. That is, when a physician tells a patient that their pain is unbearable, the physician limits the patient’s natural ability to adjust to the pain. In short, merely the narrative of a “chronic pain sufferer” can coerce the sufferer of pain to make a decision in favor of assisted suicide.³⁷

Similarly powerful cultural ideas, such as the idea that a “good death” is one

32 Carol J. Gill, “Depression in the Context of Disability and the ‘Right to Die,’” *Theoretical Medicine and Bioethics* 25 (2004): 186, <https://link.springer.com/article/10.1023/B:META.0000040058.24814.54>.

33 Sara Goering, “‘You Say You’re Happy, but...’: Contested Quality of Life Judgments in Bioethics and Disability Studies,” *Journal of Bioethical Inquiry* 5 (2008): 132, <https://link.springer.com/article/10.1007/s11673-007-9076-z>.

34 Goering, “You Say You’re Happy,” 125–26.

35 Joel Anderson and Warren Lux, “Accurate Self-Assessment, Autonomous Ignorance, and the Appreciation of Disability,” *Philosophy, Psychiatry, and Psychology* 11, no. 4 (2004): 309–12.

36 Harold Braswell, “Euthanasia,” in *Keywords for Disability Studies*, eds. Rachel Adams, Benjamin Reiss, and David Serlin (New York University Press, 2015), 80.

37 Anderson and Lux, “Accurate Self-Assessment.”

without pain, or the idea that death is better than dependence, can persuade experiencers of pain that assisted suicide is the morally desirable option, further limiting the so-called autonomy of assisted suicide.³⁸ Lastly, the Social Model contextualizes support for assisted suicide. If a non-disabled person were suicidal, they would typically be deemed irrational, and their suicidal ideation would be treated. By contrast, as Social Model theorists explain, people in chronic pain who request assisted suicide are deemed rational by physicians, politicians, and the general public.³⁹ This societal context exposes the flaws in the argument that assisted suicide confers autonomy on those with chronic pain since it is only preferable when outside parties agree that the pain experiencer “rationally” desires death. In this way, the Social Model’s framework undermines the assumption that physicians and policymakers can justify assisted suicide for chronic pain experiencers by measuring “objective” levels of pain. Rather, quality of life is determined not simply by the experience of pain but also by the societal contexts in which pain is experienced. Thus, when the Social Model is adapted to account for chronic pain, it usefully problematizes the promotion of assisted suicide for pain experiencers.

Conclusion: We Can and Should Incorporate Pain into the Social Model of Disability

To be sure, the Social Model has clear problems with the way that it conceptualizes chronic pain, particularly its claim that removing barriers will remove disabilities. However, the Social Model of Disability and the lived experience of pain need not be at odds with each other if the Social Model is modified to incorporate pain better—whether by breaking away from a literal interpretation of the model, separating out chronic pain, and theorizing the model as reducing the pain experience. While I am not advocating one specific solution, I do maintain that there is good reason to accept that chronic pain *can* be incorporated into the model. Moreover, I have proven good motivation exists *to* incorporate the Social Model into narratives of pain. The Social Model has proven useful in weighing important issues within the study of chronic pain, adding key insights into problems of individualism, motivation, and agency to the conversation on assisted suicide. While the Social Model does not offer an answer to how or if to promote assisted suicide, these insights illustrate the usefulness of the Social Model for conceptualizing pain. Thus, theorists of assisted suicide, as well as pain theorists more generally, can and should incorporate pain into the Social Model of Disability.

Works Cited

Ackerman, Felicia Nimue. “‘I Support the Right to Die. You Go First’: Bias and Physician-Assisted Suicide.” In *Palgrave Handbook of Philosophy and Public Policy*, edited by David Boonin. Palgrave Macmillan, 2018.

Albrecht, Gary L., and Judith A. Levy. “Constructing Disabilities as Social Problems.” In *Cross National Rehabilitation Policies: A Sociological Perspective*, edited by Gary L. Albrecht. Sage Publications, 1981.

Anderson, Joel, and Warren Lux. “Accurate Self-Assessment, Autonomous Ignorance, and the Appreciation of Disability.” *Philosophy, Psychiatry, and Psychology* 11,

38 Braswell, “Euthanasia,” 79.

39 Braswell, “Euthanasia,” 80.

- no. 4 (2004): 309–12.
- Barnes, Elizabeth. “The Hysteria Accusation.” *Aeon*, June 20, 2020, <https://aeon.co/essays/womens-pain-it-seems-is-hysterical-until-proven-otherwise>.
- Berger, Dan. “Recovering the History and Historiography of the Disability Rights Movement through Paul Longmore.” *Journal of Civil and Human Rights* 6, no. 2 (2020): 78–80. <https://doi.org/10.5406/jcivihumarigh.6.2.0078>.
- Braswell, Harold. “Euthanasia.” In *Keywords for Disability Studies*, edited by Rachel Adams, Benjamin Reiss, and David Serlin. New York University Press, 2015.
- Bruno, Richard L. *The Polio Paradox*. Grand Central Publishing, 2024.
- Crow, Liz. “Including All of Our Lives: Renewing the Social Model of Disability.” In *Equality, Participation, and Inclusion: Diverse Perspectives*, edited by Jonathan Rix, Melanie Nind, Kieron Sheehy, Katy Simmons, and Christopher Walsh. 2nd ed. Routledge, 2010.
- French, Sally and John Swain. “Changing Relationships for Promoting Health.” In *Tidy’s Physiotherapy*, edited by Stuart Porter. 15th ed. Churchill Livingstone, 2013.
- Gill, Carol J. “Depression in the Context of Disability and the ‘Right to Die.’” *Theoretical Medicine and Bioethics* 25 (2004): 171–98. <https://link.springer.com/article/10.1023/B:META.0000040058.24814.54>.
- Goering, Sara. “‘You Say You’re Happy, but...’: Contested Quality of Life Judgments in Bioethics and Disability Studies.” *Journal of Bioethical Inquiry* 5 (2008): 125–35. <https://link.springer.com/article/10.1007/s11673-007-9076-z>.
- Jones, Cara. “The Pain of Endo Existence: Toward a Feminist Disability Studies Reading of Endometriosis.” *Hypatia* 31, no. 3 (2016): 554–71. <https://www.jstor.org/stable/44076492>.
- Kukla, Quill. “Medicalization, ‘Normal Function,’ and the Definition of Health.” In *The Routledge Companion to Bioethics*, edited by John D. Arras, Elizabeth Fenton, and Quill Kukla. 1st ed. Routledge, 2014.
- Oliver, Michael. *The Politics of Disablement: Critical Texts in Social Work and the Welfare State*. Palgrave, 1990.
- Rogers, Emily Lim. “Recursive Debility: Symptoms, Patient Activism, and the Incomplete Medicalization of ME/CFS.” *Medical Anthropology Quarterly* 36, no. 3 (2022): 412–28. <https://doi.org/10.1111/maq.12701>.
- Shakespeare, Tom. “The Social Model of Disability.” In *The Disability Studies Reader*, edited by Lennard J. Davis. 2nd ed. Routledge, 2006.
- Stoddard Holmes, Martha. “Pain.” In *Keywords for Disability Studies*, edited by Rachel Adams, Benjamin Reiss, and David Serlin. New York University Press, 2015.
- “The Social Model of Disability.” Welsh Government Services and Information, accessed April 27, 2024. <https://www.gov.wales/sites/default/files/publications/2023-06/atn17524doc7.pdf>.
- Wendell, Susan. “Unhealthy Disabled: Treating Chronic Illnesses as Disabilities.” *Hypatia* 16, no. 4 (2001): 17–33. <https://doi.org/10.1353/hyp.2001.0062>.
- Zola, Irving Kenneth. “Self, Identity and the Naming Question: Reflections on the Language of Disability.” *Social Science & Medicine* 36, no. 2 (1993): 167–73. [https://doi.org/10.1016/0277-9536\(93\)90208-l](https://doi.org/10.1016/0277-9536(93)90208-l).