

## **CAPAPS background**

All activities in the Centre for Adapted Physical Activity Participation Studies (CAPAPS) have their origins in the United Nations Convention on the Rights of Persons with Disabilities, in the related perception of disability in context and in approaches taken in the fields of adapted physical activity and health promotion. The general perspective – disability in context – is outlined in the following paragraph followed by short descriptions of respectively adapted physical activity and health promotion.

### **1. Disability in context**

A recurrent theme in disability studies since the early 1980s provoked by the international disability rights movement has been the sharp distinction made between a physical/medical and a social model of disability. The most significant achievement, so far, of this movement is the United Nations Convention on the Rights of Persons with Disabilities, which was adopted on 13 December 2006 and marks a “paradigm shift” in attitudes and approaches to persons with disabilities:

*“It takes to a new height the movement from viewing persons with disabilities as “objects” of charity, medical treatment and social protection towards viewing persons with disabilities as “subjects” with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.”*

The focus is, therefore no longer primarily restricted to persons with individual defects or impairments but also includes social and societal aspects as reflected in the disability convention:

*“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”*

Thus, a relational perception of disability in terms of impairment in interaction with various barriers is an emergent issue at the policy and administrative level.

The move towards seeing more in disability than specific biomedical aspects is also grounded in an appreciation of the changing health experience of populations. Recent declines in a number of mortality statistics and increases in life expectancy at birth and years of life remaining after retirement age do not only represent signs of improvement in health conditions. An increase in the number of people with chronic and/or disabling conditions also forms part of the emergent picture of the state of public health.

Once the emphasis shifts from cure to care and to living with an ongoing disorder or a fragile body, diagnosis is no longer sufficient as a description of health care problems.

Therefore, a classification system dealing with the non-fatal consequences of disease and disorder was developed as a complementary tool to the International Classification of Diseases (ICD). The International Classification of Impairments, Disabilities and Handicaps (ICIDH) was published by WHO in 1980 for field trial purposes and represented another major step forward in recognizing consequences of body problems both at the level of the person and individual functioning (disability) and at that of the person as a member of society (handicapped/disadvantaged).

The ICIDH defines an impairment as follows: *“In the context of health experience, an impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function.”* Covering, as it does, losses such as that of a leg, ‘impairment’ is more inclusive than ‘disorder’ and represents deviation from some norm in the individual’s biomedical status.

Subsequently, in the context of health experience, a disability is defined as *“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”*, while a handicap is defined as *“a disadvantage for a given individual resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex and social and cultural factors) for that individual.”*

Thus, the social consequences of a deviation from some norm in the individual’s biomedical status are subsumed under the heading of a handicap in terms of a ‘disadvantage’ in a social setting. While the Body and the Disability classification relates to individuals, the Handicap classification is radically different in addressing situations in which people with disabilities are likely to find themselves.

In general, the ICIDH has caused much discussion and controversy. One of the main issues has been the negative approach to health status. In daily life and social settings, it is often more relevant to be aware of the abilities that are present than to know which abilities are lost. Therefore, variations on the deficit model, including the concept of handicap, have been associated with social oppression and discrimination, and this has highlighted a necessary shift of focus from disablement to enablement.

After a prolonged revision of the ICIDH with input from many experts and organizations, a new International Classification of Functioning, Disability and Health (ICF) was endorsed by WHO in 2001. The ICF is in part an expression of the shift of focus from disablement to enablement in that it launches ‘functioning’ as the umbrella term encompassing body functions and structures as well as activities and participation, whilst ‘disability’ is the umbrella term for impairments, limitations on activity and restriction on participation.

The ICF is more than an update of the ICIDH, since the terminology in ICF applies to everybody and is not like the ICIDH limited to certain target groups. ‘Participation’ has replaced ‘handicap’ as a key term, and both environmental and personal factors have been added as specific categories. Last - but not least, the ICF has moved away from being a ‘consequence of disease’ classification to become a ‘components of health’ classification.

Impairments are now defined as problems in body function and structure such as a significant deviation or loss, whilst limitations on activity are difficulties an individual may have in executing activities. In these respects, the ICF is not fundamentally different from the conception of impairments and disabilities (corresponding to activity limitations) in the ICIDH. On the other hand, the former concept of handicap has been replaced. In its place we now have restrictions to participation that relate not only to problems an individual may experience in involvement in life situations but also to the impact of environmental and personal factors on that involvement.

However, we may question the purpose of the distinction between activity and participation. On closer inspection it becomes evident that the notion of activity is normally supposed to cover the ‘capacity aspects’ of an action, whereas the notion of participation is supposed to cover the ‘performance aspects’ of the same action. The notion of capacity is characterized in the terms of the activity definition: “*The capacity qualifier describes an individual’s ability to execute a task or an action*”. And: “*The performance qualifier describes what an individual does in his or her current environment.*” Because the current environment brings in a social context, performance as recorded by this qualifier can also be understood as “involvement in a life situation”, which, it should be noted, is included in the very definition of participation.

There is no mention, then, of activities performed in the current situation and no mention of a capacity for involvement in a life situation, since activity in the world of ICF is limited to the execution of a task or action by an individual in a uniform or standardized environment. The purpose is, in fact, to assess a person’s ability abstractly and, to this end, the impact of environmental differences is neutralized through the invention of a standard environment within the nine domains presented as follows: 1) Learning and applying knowledge, 2) General tasks and demands, 3) Communication, 4) Mobility, 5) Self-care, 6) Domestic life, 7) Interpersonal interactions and relationships, 8) Major life areas and 9) Community, social and civic life.

However, although the environment may be standardized in those domains, it is nevertheless an environment – however it may be presented - with some influence on the person’s will or intention in action. Personal factors in terms of the particular background and experience informing a person’s life and way of living are included, though they are not classified in the ICF alongside the physical, social and attitudinal environment in which people live and conduct their lives.

The inclusion of such factors represents a radical departure from biomedical thinking, which takes illness from the universe of experience and transfers it to a location in the physical world in the form of a disease. But, since the ICF is supposed to cover the continuum of biomedical, psychological and social dimensions in a consistent and coherent manner, we should not ignore questions of subjectivity (the first person perspective) either in terms of intentionality or contextualization.

## **2. Adapted Physical Activity**

The value of physical activity and sport for all has been accepted in the public debate, but, so far, those with disabilities have been marginalized or excluded in the majority of initiatives for health promotion and in movement practices in Denmark. This is due, among other things, to a shortage of research and applied knowledge in the field of Adapted Physical Activity in the country.

The term ‘Adapted Physical Activity’ (APA) was introduced in 1973 by the founders of the International Federation of Adapted Physical Activity. While it has been employed in a variety of ways, the emphasis has increasingly been not on disabilities but on individual differences and person-environmental interactions (Hutzler and Sherrill 2007).

Based upon these trends, Reid (2003) concluded that APA should be conceptualized as “adaptations that could facilitate physical activity across a wide range of individual differences” and, in addition, should be characterized by self-determined involvement in a life span perspective.

According to Sherrill and DePauw (1997) the terminology for adapted physical activity has varied considerably (in the USA) during the twentieth century, its reference spanning from Swedish, medical, curative, or corrective gymnastics through corrective and individualized physical education and struggles between therapeutic (rehabilitative) and educational (sport) orientations to adapted physical education and – finally in the 1980s – adapted physical activity.

An important trend in adapted physical activity over the past two decades has been based on the belief that it should move away from its previous commitment to the medical model of disability (Nixon II 2000; Sherrill 2003).

Recently, however, philosophers have challenged this dichotomy between a medical and a social model in a variety of ways (Edwards 2005; Shakespeare 2006). Might there be something wrong with the demonization of the medical profession on the ground of its conceptualization of disability using the ‘medical model’? Indeed it is not evident that significant members of the medical profession ever held such a view or operated with a singular construct called ‘The medical model’ (Shakespeare 2006). Is there a sense in which both stances embody a crude generalization: disability is all natural, or all social?

If ability and disability are context-specific, do we need to acknowledge the centrality of certain contexts in living generally from those that are specifically chosen by sub-populations? How can we come to understand disability in sports and other movement activities as something other than a deviation from ‘normal’ abilities? (Jespersen and McNamee 2009)

DePauw (1997) argues that a redefinition of ability and sport is required. We must come to understand how current conceptualisation of ability in sport, physical education and movement in general enable some participants while at the same time disabling others (Evans 2004). If disability is not simply a result of some individual deviation from biomedical norms, but also and importantly the outcome of social processes, then the notions of ability and dis/ability stand in need of sustained philosophical attention and pedagogical application (Hay and Macdonald 2010).

One potential aspect of the ability-disability relation might be highlighted if we considered the temporality of disabling conditions. Consider, for example, the phenomenology of athletic injuries that have recently been investigated (Collinson 2003). Here we attempt to understand our experience of the moving body in pain, not at-one with itself, arrhythmic, ruptured or disjointed or discontinuous in its flow.

Is this not for most of ‘us’ a real and present identification with our apparently able bodies? Shedding light on our more or less articulated bodily awareness might lead ‘us’ (i) to question how closely the experience of able-bodied athletes can usefully be compared to disability populations, and (ii) to look towards “the necessary universalizing of a disability policy” (cf. Zola 1989).

Zola (1989) argued that an exclusively special needs approach to disability is inevitably a short-run approach. What we need are more universal policies that recognize that the entire population is “at risk” of suffering the aftermath of chronic illness and disability. Without such a perspective we will further create and perpetuate a segregated, separate but unequal society – a society inappropriate to a larger and older population with “changing needs”.

In his assessment Zola was fully aware of the paradox or the “dilemma of difference” (Goffman 1964), namely that political demands to end various forms of discrimination require a social analyst to identify those who are experiencing discrimination (Turner 2001). Thus, when performing specific disability studies, it is rather important to be aware of the long term perspective at the societal level.

### **2.3. Health promotion**

Health promotion policies and initiatives are aimed at the population in general. To some extent policies and initiatives are developed for sub-groups such as children, the elderly, the socially marginalized and ethnic minorities (Sundhedsstyrelsen 2010). Although health promotion initiatives aimed at individuals with disabilities flourish at the local level, no policy exists on the national level in Denmark.

One reason for the lack of a national health promotion policy for individuals with disabilities may be the scarcity of knowledge about the magnitude and distribution of behaviours that are detrimental to health. Another likely reason for the lack of a national health promotion policy is the difficulty in estimating the prevalence of disability in the population. Depending on the measures used, estimates of prevalence of disability vary considerably from about 10 to more than 25% within the same sample (Molden and Tøssebro 2010) Furthermore, existing measures used for the classification of disability may not capture important aspects of the disabled individuals’ living conditions that are conducive to a healthy behaviour.

## 9. References

- Collison, A. (2003). Running into injury time: Distance running and temporality. *Sociology of Sport Journal* 20: 331-50.
- DePauw, K. P. (1997). The (in)visibility of disability: Cultural Contexts and "sporting bodies." *Quest* 49: 416-30.
- Edwards, S. D. (2005). *Disability: Definitions, Value and Identity*. Abingdon: Radcliffe.
- Evans, J. (2004). Making a difference? Education and 'ability' in physical education. *European Physical Education Review* 10 (1): 95-98.
- Goffman, E. (1964). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.
- Hay, P. J. and D. Macdonald. (2010). Evidence for the social construction of ability in physical education. *Sport, Education and Society* 15 (1): 1-18.
- Hutzler, Y. and C. Sherrill (2007). Defining Adapted Physical Activity: International Perspectives. *Adapted Physical Activity Quarterly* 24: 1-20.
- Jespersen, E. and M. McNamee. (Eds.) (2009). *Ethics, Dis/Ability and Sports*. London and New York: Routledge.
- Molden, T. H. and J. Tøssebro (2010): Measuring disability in survey research: Comparing current measurements within one data set. *ALTER, European Journal of Disability Research* 4: 174-189.
- Nixon II, H. L. (2000). Sport and disability. In J. Coakley and E. Dunning. *Handbook of Sports Studies*. (pp. 422-438). London: Sage.
- Reid, G. (2003). Defining adapted physical activity. In R. D. Steadward, G. D. Wheeler, et al. (Eds.) *Adapted Physical Activity* (pp. 11-25). Edmonton: University of Alberta Press.
- Shakespeare, T. (2006). *Disability: Rights and Wrongs*. London: Routledge.
- Sherrill, C. (2003). *Adapted Physical Activity, Recreation and Sport. Crossdisciplinary and Lifespan*. 6<sup>th</sup> edn. Boston, MA: McGraw Hill.
- Sherrill, C. and K. DePauw (1997). Adapted physical education and education. In J. D. Massengale and R. A. Swanson (Eds.). *The history of Exercise and Sport Science* (pp. 39-108). Champaign, IL: Human Kinetics.
- Sundhedsstyrelsen. (2008). *Vejledning om adgang til vederlagsfri fysioterapi (Instruction on access to physiotherapy free-of-charge)*. Retrieved September, 2008, from <http://www.sst.dk>.
- Turner, B. S. (2001). Disability and the Sociology of the Body. In G. L. Albrecht, K. D. Seelman et al. *Handbook of Disability Studies*. (pp. 252-266). Thousand Oaks: Sage Publications.
- UN: *United Nations Convention on the Rights of Persons with Disabilities* (2006).
- WHO. (1980). *ICIDH. International Classification of Impairments, Disabilities and Handicaps*.
- WHO. (2001). *ICF. International Classification of Functioning, Disability and Health*.
- Zola, I. K. (1989). Toward the necessary universalizing of a disability policy. *The Milbank Quarterly* 67 (Suppl. 2): 401-28.

