



Articles



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Controversies around the social model of disability

KEYWORDS

social environment, disability, impairment, disabling barriers, oppression, identity

ABSTRACT

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The aim of the article is to present a critical analysis of the social model of disability.

In the first part, the author discusses the genesis, essence and basic advantages of the social model of disability. Next, five major disadvantages of this model are analysed: /1/ avoiding dealing with impairment as an important aspect of the lives of people with disabilities, /2/ separating impairment from disability, /3/ assuming that all people with disabilities are exposed to social oppression, /4/ postulating the creation of an environment without barriers and /5/ assuming that disability is the basis of the identity of people affected by it. In the final part of the article, the author presents reflections on the possibility of creating a new, more holistic model of disability.

Introduction

The discussion regarding manners of understanding the concept of disability has a significant meaning for all those that deal with persons with disabilities both, in scientific research and in practice. The commonly accepted model of disability

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influences the social policy towards persons with disabilities and measures undertaken by professionals – special educators, psychologists, social workers, doctors, physical therapists and others. The preferred model of disability has a decisive impact on measures undertaken in order to prevent and eliminate disability and minimise consequences thereof. Furthermore, the preferred model of disability determines the manner of stipulating aims of education and rehabilitation of persons with disabilities and the methods that will be used to achieve those aims. However, the prevailing model of disability primarily determines the place of persons with disabilities in the society and the manner in which their civil rights to equal treatment, self-determination, education, work and relaxation, are exercised. Therefore, it is so important that the persons concerned, that is, persons with disabilities have an actual impact on how the disability is understood by the society and thus, how they are treated by the society. The able-bodied majority should respect the right of persons with disabilities to decide in matters concerning them. It should be, in fact, remembered that persons with disabilities constitute 15% of human population, which means that currently there are approximately 1.1 billion of them in the world.

The aim of the article is to present a critical analysis of the social model of disability hitherto commonly accepted. I will start with presenting the genesis, essence and main advantages of this model. Then, I will present five most important disadvantages of the social model. In the last part of the article, I will indicate the possibility of a new, more holistic approach to disability.

The genesis, essence and advantages of the social model of disability

The beginnings of the social model of disability go back to the year 1966, when Paul Hunt suffering from spinal muscular atrophy, resident of the nursing home in Hampshire (England) edited a collective work entitled *Stigma: The Experience of Disability* (Hunt, 1996). The work consists of 12 texts written by persons with disabilities – six women and six men. The contents thereof broke through the opinion prevailing at that time that disability is of a medical character and is a personal tragedy of a person suffering from such disability. In 1972, after leaving the nursing home, Paul Hunt established the UPIAS – Union of the Physically Impaired Against Segregation. UPIAS attracted a small, but very active group of persons with physical disabilities, who, in their activity, were inspired by the theory of Historical Materialism of Karol Marx and by the Western Marxist sociology. The aim

of the Union was to eliminate institutional forms of care over persons with disabilities and, at the same time, to provide them with full participation in social life, independent existence, the possibility to start work and the right to decide on their own fate.

In 1976 the British Union of the Physically Impaired Against Segregation (UPIAS) announced a manifest entitled *Fundamental Principles of Disability*. The manifest includes the significant statement:

In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments, by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. (*Union of the Physically...: 3–4*)

This statement was later extended and it also covered persons with sensory disabilities and intellectual disability.

The foundation of the social disability model constitutes the distinction between impairment (physical disability) and disability understood as a consequence of oppressive treatment by social environment.¹ UPIAS defines “impairment as lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body.” Whereas, disability is defined as “the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities.” (*Union of the Physically...: 3–4*). The proposed by UPIAS understanding of the terms: impairment and disability allows understanding how the social model differs from the previous, medical model. Namely, in the medical model disability is treated as a biologically determined defect, whereas, in the social model – as a result of social barriers.

In the social model disability has a relative character. It predominantly results from the character of the interaction between a person with disability and the environment in which he or she lives. Impairment of a body or a functional limitation cannot constitute grounds for considering a person as a person with disability. A person becomes disabled only when their participation in social life becomes very limited or simply impossible. It happens due to two types of barriers. The first one comprises physical barriers, that is, impediments: in movements, access to buildings, using public transport etc. The second one comprises social barriers

¹ In the Polish subject literature the concept of “niepełnosprawność” (“disability”) functions as least stigmatizing substitute of the previously used term “upośledzenie” (“handicap”). In English the concept of disability primarily underlines social aspects of a damage to an organism or its function.

resulting from stereotypes concerning persons with disabilities leading to their stigmatisation (Twardowski, 2017: 17–18). According to the assumptions of the social model

Disability occurs only when faced with barriers for which the society is responsible. Impairments to the body do not create disability in social sense. Only limitations resulting from non-adaptation of the society decide on the fact, whether the person is or is not excluded from such society. (Karaś, 2012: 24)

As briefly stated by Harlan Hahn (1986), disability results from the failure in adjusting social environment to the needs and aspirations of citizens with physical impairments and not from the inability of those persons to adjust to requirements of the society.

The second key element of the social model is the thesis that persons with disabilities are subject to oppression irrespectively of the social-political system of the society in which they live and the predominant religion. According to Colin Barnes and Geof Mercer (2008: 30–31) oppression can take on five main forms: exploitation, marginalisation, helplessness, cultural imperialism and violence. *Exploitation* is demonstrated in offering persons with disabilities, against their will, the lowest remuneration. It can also have a more indirect form consisting in obtaining financial benefits from saving health and improving the quality of life of persons with disabilities. The essence of *marginalisation* is to systematically eliminate persons with disabilities from the mainstream of everyday life, among others, by excluding them from the division of work, institutional segregation and depriving of civil rights. *Helplessness* consists in causing persons with disabilities to feel that they have little choice or small control over own lives. Helplessness reinforces the division into those with authority and power and those deprived of the authority and “executing orders”. *Cultural imperialism* is expressed in creating a negative image of disability with a simultaneous promotion of “able-bodied normality” as a privileged and desired condition. Persons with disabilities are put aside as “Others”, that is, people who are in a way abnormal. Whereas, *violence* against persons with disabilities may have a character of a physical, sexual or verbal assault, but it may be also expressed in the eugenics policy.

Social oppression leads to the institutional discrimination analogous to the one experienced by representatives of ethnical, racial and sexual minorities. Len Barton (1993: 242) underlines that the scope of the institutional discrimination experienced by persons with disabilities is significant. Discrimination consists in preventing or restricting participation in such areas, as: work, housing, education, transport, entertainment, social benefits. Therefore, the issue of oppression signif-

icantly exceeds negative approaches of people meeting persons with disabilities. It has broader historical, economic, political and social conditions. Charity and social aid will not suffice to solve this issue effectively.

For centuries persons with disabilities have encountered oppressive approaches of the able-bodied majority. These approaches have been manifested by, among others: terror, fear, anxiety, hostility, distrust, pity, overprotectiveness, paternalism. Negative approaches in connection with unfriendly physical environment are real problems encountered by persons with disabilities. Therefore, as underlined by Colin Barnes (1991), persons with disabilities live in a world which disables them. Defining discrimination of persons with disabilities as a kind of social oppression originates from the belief that persons with disabilities, due to their disability, have to subject to the able-bodied majority. Within this majority, persons with disabilities are perceived as “defective” or “abnormal”, and thus, stigmatised as a separate social group and treated differently (Barnes, Mercer, 2008: 29).

James Charlton believes that the oppression experienced by the majority of persons with disabilities is so long-lasting and strong that it is subject to internalisation in a form of so-called: “false consciousness”² of self and the surrounding reality. The false consciousness is a peculiar mixture of self-pity, self-hate and shame. Manifestations of this type of consciousness

prevent people with disabilities from knowing their real selves, their real needs, and their real capabilities and from recognizing the options they in fact have. False consciousness and alienation also obscure the source of their oppression. They cannot recognize that their self-perceived pitiful lives are simply a perverse mirroring of a pitiful world order. (Charlton, 1998: 27)

Social model of disability became “a great idea” integrating persons with disabilities and motivating them to fight for equal rights. In the 80s and 90s of the 20th century it constituted the basis of the campaign for introduction of anti-discriminatory legal solutions. The activities inspired by the social model of disability relatively quickly started generating measurable benefits. Solutions facilitating everyday life for persons with disabilities occurred, for example adjusted to their needs: signs, telephones, toilets, elevators, public transport means, technical aids. Furthermore, provisions allowing children and youth with disabilities to undergo education in generally available schools were introduced. A great attention started to be paid to eliminating architectural barriers and employing persons with disabilities at properly adjusted worksites.

² The author borrowed this term from the theory of Karl Marx.

The social model of disability had a positive impact on the awareness of the able-bodied majority and its approach to persons with disabilities. The model effectively showed that problems encountered by persons with disabilities result from social oppression and exclusion and not their individual deficits. Therefore, the model imposed on the society the moral responsibility for removing limitations that had been imposed on persons with disabilities and had prevented them from full participation in the social life and achieving personal happiness. As noticed by Michael Olivier (2004), the social model was to a smaller extent a theory, idea or conception and to a greater extent, a practical tool that contributed to the equal rights of persons with disabilities.

The social model had a beneficial, psychological impact on persons with disabilities – it improved their self-assessment and helped in building positive identity. At this point it is worth reminding that the medical model of disability concentrated on physical deficits and limitations of an individual. It favoured developing by such a person a sense of guilt, low self-esteem and a lack of self-confidence. On the other hand, the social model encouraged the person with disability to change the manner of perceiving themselves and their situation. In compliance with the social model, the source of disability does not consist in individual features of an individual, but approaches of other people, as well as physical and social barriers. A disabled individual does not have to change; it is the society that should change. A person with disability does not have to pity themselves; they have the right to feel anger and pride (Shakespeare, 2006: 199–200).

The social model of disability also had a wider, more positive impact. It started rapidly developing artistic creativity of persons with disabilities: musical, artistic, literary, film and theatrical. Disabled scientists, such as: Victor Finkelstein, Colin Barnes, Jenny Morris, Michael Oliver, who co-created this model, then, used it in their own research (Barnes, 2012: 25). These studies, especially of a qualitative character, presented the life situation of persons with disabilities from their own perspective. The following topics were discussed: media image of disability, old age and aging of persons with disabilities, independent life, disability in various cultures, races and ethnical groups, romantic relationships, sexuality and parenthood of persons with disabilities (Twardowski, 2018: 107).

Criticism of the social model of disability

The social model of disability became an effective weapon to the benefit of equal rights of persons with disabilities. With time it started being treated as ideology,

which is difficult to be questioned. It partially resulted from the simplicity of the model that could be reduced to strong slogans, such as: “The source of our disability is the society and not our bodies”, “We are the victims of oppression, not oppressors”, “We concentrate on the disability and not on impairments”. First, critical opinions on the social model occurred at the turn of the 20th and 21st century. As noticed by Tom Shakespeare and Nicholas Watson (2002: 14) what was the strength of the social model of disability became its weakness. The model became obsolete and started generating more problems than solutions.

The undeniable defect of the social model is avoiding dealing with the impairment of body as a significant aspect of lives of many persons with disabilities. Feminists with physical disabilities: Jenny Morris, Liz Crow and Sally French were pioneers of criticism of the social model in this scope. The latter explains why representatives of the social model of disability unwillingly deal with impairments:

Undoubtedly, activists, who have been tirelessly working for many years to the benefit of equal rights of persons with disabilities, considered it necessary to present disability in a simple and approachable manner in order to convince the very sceptical world that disability can be reduced or eliminated by changing the society rather than trying to change the persons with disabilities themselves. (French, 2004: 84)

However, ignoring impairments leads to rejection of a very important aspect of lives of persons with disabilities. Moreover, it prevents such persons from sharing their experiences related to own body. Therefore, Jenny Morris postulates to conduct research, analyse and describe physical and psychological experiences coming from “the personal experience of our bodies and our minds for if we don’t impose our own definitions and perspectives then the non-disabled world will continue to do it for us in ways which alienate and disempower us.” (Morris, 2001: 10). It is a fact that persons with disabilities have impaired bodies and cannot deny it without the risk that thus they would ignore an important part of own biography. Of course, as postulated by the social model, in the policy regarding persons with disabilities a priority should be to introduce social changes and eliminate barriers. Nevertheless, there is no reason for medical procedures aimed at eliminating or reducing bodily impairments not to co-exist with activities aimed at eliminating disabling social practices. After all, persons with disabilities are disabled both, by social barriers and own bodies.

The distinction between impairment, that is, a feature of a body or mind of a given person and disability understood as a relation between persons with impairments and the society, adopted by the supporters of the social model of disability, raises doubts. The purpose of this binary distinction is to reduce the bodily

dimension of disability and thus, negate the causal link between impairment and disability and establish a new link: between an individual and social environment. However, treating disability as conditioned only by social factors is difficult to accept, as it is contrary to life experience. The correctness of the distinction between impairment and disability can be questioned by asking the following question: where does the impairment end and the disability start? Sometimes, thus asked question cannot be answered explicitly, since, as noticed by Liz Crow "Some impediments, such as chronic pain or chronic disease may hinder functioning of an individual to such an extent that various limitations imposed by the social environment become insignificant (...) on the other hand, other persons with disabilities still have to deal with impairment, despite the fact that the disabling social barriers were eliminated a long time ago." (Crow, 1996: 209). In real life situations it is very difficult to separate impairment from the impact of social barriers. Usually both of these factors interact and presence of one of them is a precondition, yet, not sufficient condition, to identify the reasons of disability. For example, it is difficult to determine, whether the source of depression of a person suffering from multiple sclerosis is: (1) the disease itself, (2) experiencing the illness by the person, (3) discriminatory approach of the social environment towards the sick person, (4) mutual interaction of the aforementioned factors or (5) other reason. Therefore, individual and social conditions of disability occur in mutual, complex interdependencies.

The social model is based on the assumption that all persons with disabilities are exposed to social oppression. More specifically, oppression is treated as mutual experience of all persons with disabilities irrespectively of their impairments and social environments they live in. This assumption is not true, as the concepts of "impairment" and "disability" are socially constructed and are understood differently in different socio-cultural contexts. This, in turn, means that a social model of disability, which would have a universal character, cannot be created. For example, a person with dyslexia living in a village in South India will most probably not be considered as disabled and he or she will not be affected by any oppression. This person will be able to work and fully participate in the life of the local community. Whereas, in Western European country a person with dyslexia will be at a risk of unemployment and will face difficulties in social functioning. Furthermore, the relation between impairment and oppression is more complex, since impairments are not always visible. If they concern mental processes, then, although not directly observable, they can significantly hinder functioning of an individual and put him or her at a risk of strong oppression from the society. It can be the case with persons suffering from mental diseases or autism spectrum disorders. Furthermore,

the creators of the social model of disability did not explain the mechanism of oppression. They stated that approaches constitute the source of oppression. However, it is not enough to understand how oppressive approaches develop and how they are demonstrated in specific behaviours towards persons with disabilities.

Certainly, persons with disabilities face oppression. However, disability is such a complex phenomenon that it cannot be explained only with social pressure and discrimination. Many people contact persons with disabilities in improper manner not because they wish to put pressure on them, but because they know nothing about them and/or are afraid of them. This thesis is confirmed by Jenny Morris, who writes:

Our disability frightens people. They don't want to think that this is something which could happen to them. So we become separated from common humanity, treated as fundamentally different and alien. Having put up clear barriers between us and them, non-disabled people further hide their fear and discomfort by turning us into objects of pity, comforting themselves with their own kindness and generosity. (Morris, 1991: 192)

Thus, the reasons for oppressive treatment of persons with disabilities can constitute the lack of knowledge and fear. And then, education will be the best manner of eliminating negative approaches towards persons with disabilities.

A crucial element of the social model of disability constitutes the postulate for an environment without barriers. Unfortunately, implementation thereof is impossible. As noticed by Tom Shakespeare (2006: 201–202), persons with disabilities do not have access to many elements of natural environment: persons on wheelchairs to beaches and mountains, blind persons to the view of a sunset and deaf persons to bird songs. Furthermore, what is a barrier for persons with a given type of disability does not have to be a barrier for persons with other disability. For example, blind persons prefer stairs and well-designated curbs, whereas, persons on wheelchairs – smooth surfaces, ramps and gentle driveways. Sometimes persons with the same type of disability need different adjustments. For example, people with impaired eyesight should be provided with texts written in Braille or large font, or audio recordings. It should be noticed that in the case of persons with physical and sensor disabilities, it is possible to eliminate many barriers, but not all. Therefore, one should agree with the opinion of Michael Bury (1997: 137) that it is difficult to imagine contemporary industrial society, where, for example, a significant limitation of mobility, manual dexterity, ability to see or hear would not be “excluding”, that is, would not limit the individual's activity. Thus, eliminating barriers hindering participation does not mean eliminating disability as such.

It should be noticed that removing some obstacles is very difficult or even impossible. It is so in the case of barriers that are not situated in the external physical or social environment, but are of an internal character, that is, constitute features of a body or psyche of a person with disability. Then, various questions arise. For instance: "If impairment causes permanent pain, can any changes in the social environment reduce it?", "If a given person has severe intellectual disability, how should the social environment be changed to employ such a person?", "How should barrier-free environment look like in the case of persons with autism spectrum disorders, mental disorders or complex disabilities?" The aforementioned questions prove that creating barrier-free environment, where all persons with disabilities could live and work is a utopia (Abberley, 1996: 79).

In the social model it is silently assumed that persons with disabilities identify themselves as such. Meanwhile, many persons with disabilities do not perceive themselves as disabled in categories of the medical model or social model. They reject or ignore their impairments and strive to obtain access to the identity of the mainstream. The explicit unwillingness to identify themselves as persons with disabilities can be also observed among schoolchildren. For example, Mark Priestley, Mairian Corker and Nick Watson proved that children with disabilities could identify social barriers they came across and often complained about the treatment they were undergoing. However, in the vast majority they wanted to be perceived as normal, though different. They primarily objected identifying them as disabled (Priestley, Corker, Watson, 1999). Whereas, Tom Shakespeare, Katharine Gillespie-Sells and Dominic Davies (1996) proved that homosexual persons with disabilities put their sexual identity on the first place and ignore experiences related to disability.

The assumption that disability is to constitute a basis of people's identity suffering therefrom, is a repeated mistake made by the supporters of the medical model, who defined people due to their impairments. Identity of each person has many dimensions. Thus, each person with disability has the right to identify not only as a representative of the disabled minority, but also due to their cultural gender, ethnicity, sexual orientation, occupation, religion or even supported football team. The human identity is not invariable. It is an issue of choice within specific boundaries (Shakespeare, Watson, 2002; 21).

Towards the holistic model of disability

Undoubtedly, the social model of disability brought a lot of benefits. It initiated the movement to the benefit of equal rights of the persons with disabilities and helped

them to develop positive collective identity. It contributed to eliminating numerous barriers hindering social integration of persons with disabilities. It became a useful tool of disclosing and counteracting symptoms of discrimination and exclusion. However, currently the up-to-dateness of the social model of disability established in the early 1970s and developed for consecutive decades, is debatable. The basic flaw of the social model is the fact that it breaks the relation between impairment, that is, the feature of the body, and disability, which is treated as the socio-cultural construct. It may be said that the supporters of the social model copy the 17th century, Cartesian division into non-materialistic mind and physical body. It is strongly demonstrated in Michel Oliver's statement that "disability has nothing common with the body" and "impairment is basically the physical condition of the body" (Oliver, 1995: 4–5). Such an arbitrary division raises serious doubts. The following question arises: "Can mutual relations between *psyche* and *soma* be omitted in explanation of the essence of disability?" It is, indeed, difficult to ignore cognitive and emotional states of an individual, especially, if impairment is accompanied by strong, chronic pain or, when impairment drastically limits everyday functioning of an individual. One may also wonder, if it is possible to formulate a definition that would encompass all types of disability and apply to all socio-cultural environments.

The hope for creating one coherent manner of understanding disability occurred in the year 2001 due to the International Classification of Functioning, Disability and Health (so-called ICF) adopted by the WHO. Currently on its websites, WHO states that

disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. (*Disabilities – World Health Organization...*)

In the definition proposed by the WHO disability is treated as tridimensional phenomenon resulting from mutual dynamic relations between the individual's health condition and the social environment. Activity limitation is not a feature attributed to an individual, but a consequence of relations between the individual and its physical and social environment. Impairment such as the inability to walk, talk, hear or see becomes disability only when the environment significantly hinders or prevents the individual from activity and participation. In its definition,

the WHO neither found a balance between the medical and social models of disabilities, nor connected those models. The WHO's proposition implies two interpretations of disability. According to the first one, disability is the inability to live an active life in a manner typical for an able-bodied person of the same gender and at the same age. Whereas, according to the second one, disabilities are the inability to take social roles resulting in the limitation of life activity. Both interpretations overlap and in both of them, the primary source of disability consists in the individual's impairment. Each draws attention to other aspect of disability, but neither integrates all of its elements.

Therefore, can such a model of disability be created that would integrate all of its dimensions: bodily, psychological and socio-cultural? Undoubtedly, yes. However, in order to do so, one should look at the essence of disability differently. It should be primarily assumed that there is no qualitative difference between able-bodied people and persons with disabilities, since every person has some impairments, is exposed to limitations and along with the aging process will experience a decrease in dexterity and more and more often suffer from various diseases. Therefore, division into able-bodied and disabled persons is invalid. For example, the research conducted within the Human Genome Project proved that a genome of each person included mutations predestining for diseases occurring in old age, such as: tumours, cardiovascular diseases, neurodegeneration diseases and other. Moreover, every person has between four and five recessive genes that can cause a genetic disease in offspring, if the other parent is a carrier of the same genes. It is not possible for the human body and mind to always function without any disturbances. Organisms of all people, at least in certain periods of life, are vulnerable to various dysfunctions and impairments. Undoubtedly suffering and illness constitute elements of our human condition and death is attributed to our existence.³

If it is stated that diseases and physical impairments are natural elements of existence of each person, then, using the statistical norm is no longer needed. Unfortunately, still, both, in the diagnostic practice and in social awareness, this norm is prevailing. While assessing someone's dexterity we compare it with dexterity of other people at the same age and from the same environment. It means that the society itself produces the so-called norm and then, using its assessments, puts pressure on persons "outside the norm" to adjust thereto independently or with the support of specialists. Therefore, as a consequence of assessing people from the point of view of a norm, we observe adjustment thereto, as well as segregation and

³ This thought is very aptly reflected in the title and plot of Krzysztof Zanussi's film *Life as a Fatal Sexually Transmitted Disease*.

stigmatisation. Those are the activities violating human subjectivity and dignity. It is, in fact, “not a person who is handicapped or retarded in any manner. He or she is in the essence of their humanity intact; it is their development that is hindered.” (Obuchowska, 1984: 4–5). Undoubtedly, the functional norm is more humanistic than the statistical norm, as it refers to individual abilities of a specific person and is devoid of both, pressure and stigmatisation.

As rightly noticed by Irena Obuchowska, there are no persons always and in all respects disabled and able-bodied. It is, in fact, a feature of a human nature that the scope and level of dexterity of various people are different and thus, our social life becomes more diversified. “And it is also true that despite various disabilities and limitations, people are able to live their lives in a useful manner with a sense of meaning, implementing various variants thereof. What is, in fact, important in human life is not with what a human has been equipped by nature, but what such a human does with his or her, better or worse, equipment, what is important for them, what choices they make.” (Obuchowska, 1991: 10). The quoted belief formulated almost three decades ago, remains up-to-date. For instance, Elżbieta Zakrzewska-Manterys in her text concerning intellectual disability included the following belief: “mental handicap does not have to be treated as a lack of something or dysfunction, but it may be – in compliance with the policy of diversity – treated as equal manner of being a human, different than the manner of manifesting humanity among statistical majority of citizens, yet, distinguished with specific characteristics and beauty.” (Zakrzewska-Manterys, 2015: 95).

Conclusion

With reference to the conception of Thomas Khun, it can be stated that the medical model was a traditional paradigm of disability. However, with time, when persons with disabilities started noticing that it is not a proper manner of understanding their functioning, the paradigm changed.⁴ The social model of disability occurred, which was more effective in explaining experiences of persons with disabilities and identifying reasons of their unfavourable situation. It seems that it is time for another change of the model of disability. However, it should be remembered

⁴ According to Thomas Kuhn, a paradigm is a generally accepted by the community of scientists, thought system comprising: the most general assumptions and conceptual models, theories and established facts, as well as issues raised in studies and typical techniques of solving them. A paradigm is established in the course of many years of reliable research and adopted by consensus (see: Kuhn, 2001).

that shifting to a new paradigm does not mean rejecting the previous one. Indeed, in physics replacing Newton's mechanics with Einstein's theory of relativity did not invalidate the previous approach, but only showed its limitations. Despite shortages of the social model of disability indicated herein, its main messages remain valid: social and physical barriers should be eliminated and one should act to the benefit of equal rights, empowering and self-determination of persons with disabilities. Whereas, what seems necessary, is the change of the approach to the essence of disability. Instead of idle disputes whether disability has a medical or social character, one should strive for development of such a model that would integrate all dimensions thereof: biological, psychological, cultural, social and political. However, primarily the assumption that disability is a feature of all people and not only some of them, should be adopted.

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