

Discourses of disability and inclusive education

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The medical model and the social model are two different discourses of disability that affect how society perceives individuals with impairments. The medical model relies heavily on the medicalisation of disability. Whilst the social model promotes that an individual has an impairment but it is societal barriers that create the disability. Although there are many discourses in disability, this article discusses the medical and social model, both dominant models in education. These discourses can impact and influence policy and practice in society and determine how individuals with impairments are responded to in an educational setting. This paper also reflects on how the social model came to underpin inclusive education philosophy and examines current arguments concerning the theoretical and practical implementation of both models in society. In conclusion, a combination of the positive aspects of each discourse and a balance in real-life application would be advantageous to individuals with impairments and society as a whole.

In all societies there are individuals who have physical, cognitive or social impairments, inciting the inevitable judgement in that society of what is normal and what is not (Winzer, 2007). Throughout history, societal barriers towards individuals with impairments have supported the marginalisation and discrimination of the disabled community. Conventional views regard disability as a tragedy, causing life-long suffering for the individual and limiting their opportunities and participation in the community (Vehmas, 2004). The social model arose to challenge these perceptions, and over the last fifty years, both the medical model and the social model have contributed to the understanding of disability, yet each have very different concepts regarding disability and society (Haegele & Hodge, 2016). The medical model considers disability a consequence of an individual's deficit in biological function, but the social model does not support this view. It was developed in response to the medical model, dividing the concepts of impairment and disability. The impairment of an individual being simply a body malfunction or defect and 'disability' the "disadvantage or restriction of activity caused by contemporary organisation" (UPIAS as cited in Lang, 2001, p. 7; Anastasiou & Kauffman, 2011).

This means that the term disability is conceptualised in society as being a disadvantage or restriction on many activities, for example in the workplace or in schools. Whereas impairment means there something wrong with the body but it should not be considered a disadvantage, just a difference.

The social model advocates that disability is caused by social oppression and prejudices, a reaction of society to impairments that subsequently initiate environmental barriers and attitudinal discrimination and oppression (Beaudry, 2016; Lang, 2001). There are many differences between the medical and social model. Primarily, the medical model perceives disability as a biological problem in need of medical fixation. In contrast, the social model sees society as creating disability through physical and social barriers (Owens, 2015). The social model became the dominant model in underpinning inclusive education because it is very similar to the fundamental philosophies of inclusion, especially concerning attitudes and equal opportunities in an educational context.

A fundamental difference between the models is how the individual with an impairment is defined and typified in society. The medical model asserts that disability is a biological product, and as this deficit is within the individual, this problem can, or should be, 'fixed', allowing the person to be able to function in society (Haegele & Hodge, 2016; Kattari, Lavery, & Hasche, 2017; Vehmas, 2004). As disability in the medical model is considered abnormal, it presumes a main goal of the individual is to be cured so they can be 'normal' (Kearney & Kane, 2006). This model postulates physiological and psychological factors are the primary causes of a disability. It does not recognise other factors that

may impact the individual or how they interact with the environment (DeJong, 1979; Watson as cited in Kattari et al., 2017; Oliver as cited in Anastasiou & Kauffman, 2011). It only considers the bodily dysfunction as the source of the disability. In contrast, the social model recognises that the biological impairment is not the defining feature or dominant characteristic of the person, and that society has little or no consideration for these individuals, therefore restricting their participation in the community (Goodley as cited in Haegele & Hodge, 2016). It does not consider an impairment something sick which needs to be repaired, but advocates that the actions of society create the disability through lack of accommodation (Brownlow, 2010; Kattari et al., 2017; Haegele & Hodge, 2016; Neilson, 2000).

This is how the social model became a dominant basis for inclusive education. In inclusive education, a student is not only defined by their biological dysfunction or labelled as disabled, but is recognised as a person beyond their impairment. In an early childhood context, a child is not automatically categorised and associated with by their disability but given opportunity to work and play alongside their peers and perhaps exceed expectations, without the weight of a label. Kliewer and Biken (as cited in Anastasiou & Kauffman, 2011) commented that “labels block the essential agenda of good teaching... who wants to be called retarded?” (p. 373). No child should grow up with a label of being less-than, as this could have serious long-term consequences on their self-esteem and the perception of themselves compared to others. By acknowledging impairments as a difference in a child rather than having an identity because of their disability, the social model is fundamental for inclusive education. It gives opportunity for flexibility towards the needs of all learners and their families, trusting the experience and personal expectations of the individual over institutionalised knowledge and assumptions (Ministry of Education, 2018; Kattari et al., 2017). In inclusive education, the social model looks at the individual holistically, still taking into consideration their impairment, but not limiting them by it regarding their educational experience.

Another significant difference between the medical model and the social model concerns the subjective societal attitudes towards individuals with impairments. The medical model is based on the medicalisation of disability and being within a person. Therefore, the need for treatment must come from an external source, such as a doctor or therapist (Shyman, 2016). This model sets boundaries of who needs to be cured and who does the curing. This concept inadvertently influences how society views disability (Anastasiou & Kauffman, 2011). Society sees disability as a misfortune, a hardship, something an individual must endure as their quality of life is mediocre with limited opportunities. The medical model also generates emotive reactions of sympathy, pity and reservation. It perpetuates social deviance, affecting societal attitudes and causing negative conceptions that enable marginalisation and discriminatory acts such as stereotyping and labelling (Grue, 2016; Shyman, 2016; Terzi, 2014; Oliver as cited in Anastasiou & Kauffman, 2011). Societal attitudes are a huge barrier for individuals with disabilities, yet the medical profession continues to hold the power in determining what is normal and abnormal, so does their influence over the treatment of individuals with impairments in society (Fisher & Goodley, 2007; Haegele & Hodge, 2016; Lang, 2001; Neilson, 2000). In contrast, the social model considers individuals with impairments as a diversity, not an abnormality, and does not condone a full dependence on the medical profession for all aspects concerning their livelihood (Haegele & Hodge, 2016; Low, 2010). It promotes disability as a social creation of prejudice and discrimination, “something imposed on top of our impairments, by the way we are unnecessarily isolated and excluded from full participation in society” (UPIAS as cited in Gallagher et al., 2014, p. 1122). The social model aims to shift the perceptions of disability away from the presumed need for acceptance towards acceptance in society as a human right. The autism society fight for their right to be autistic through the neurodiversity movement, claiming autism is simply a difference rather than a dysfunction, and they do not need to change because of it (Owren & Stenhammer, 2013). This model promotes a societal need for intervention that encourages change in thought from the community, advocating that disability is caused by physical barriers and from the prevailing perceptions people maintain (Vehmas, 2004). Hughes and Paterson (1997) note “disabled people have been cast in a role of the other” (p. 325), and disability is a tragedy and these individuals are victims of unfortunate circumstances. However, the social model maintains impairment is a biological dysfunction and disability is the processes of social exclusion, not just physically but also attitudinal (Hughes &

Paterson, 1997). If people without disabilities altered socially built-in perspectives of disability, these attitudes would break down psychological barriers towards individuals with impairments.

The social model underpins inclusive education as it encourages the acceptance of all individuals with impairments and this resonates with the philosophy of inclusive education. Special education is based on the medical model conception that reinforces unfavourable attitudes of the school community towards disability. As placement in these classes is based on a student's diagnosis, special education continues to promote attitudes of disability being tragic and undesirable, consequently further excluding and oppressing these students (Naraian & Schlessinger, 2017). Attitudes from the school community can have a powerful effect on a child's aptitude for learning, how they approach education and their own perception of themselves.

In the early childhood classroom, a concept of disability can influence a teacher's attitude and expectations towards a child with impairments, and how a teacher interacts and perceives this child is "critical to a successful educational experience" (Lytle & Collier as cited in Haegele & Hodge, 2016, p. 199). Teachers, other children and members in the school community are also influenced by conceptions of disability, sub-consciously judging and categorising students with impairments immediately because of their physicality, the way they behave around others, their ability to perform in class or their immediate diagnosis. Teachers may automatically assume a child does not have the mental capacity for classroom work or activities, and other children may distance themselves from an individual for a variety of reasons such as they do not understand the disability therefore are fearful of it, thus being less willing to accept the child into their social circle. However, positive perceptions can influence a child's approach to learning. Children with impairments respond positively to learning alongside their peers, and enjoy having responsibilities and opportunities in class (Neilson, 2000). Acceptance by their teachers and peers not only facilitates their self-esteem but also motivates them to learn in an environment that could have otherwise promoted integration rather than inclusion. Changing adverse concepts towards disability with the inclusion of all children in the classroom regardless of their diagnosis or disability label resonates with the social model philosophy.

Environmental factors and the impact these have on a person's disability can be a deciding factor between participation and exclusion in society and it can cause contention between the two discourses. Originally, the social model was conceived when only referring to physical impairments, especially regarding physically disabling barriers, but later included intellectual impairments which can be just as exclusionary (Barnes & Mercer as cited in Brownlow, 2010). However, actual physical barriers in society are a major obstacle for individuals with impairments concerning access to the community. The social model advocates that environmental factors create disability by restricting activity, and the blame and responsibility for these limitations should not be placed on the individual (Terzi, 2014; Neilson, 2000). A child in a wheelchair has no problem with their impairment until they encounter stairs, becoming disabled by the environment, but it is not their fault society favours those who can walk (Owren & Stenhammer, 2013). Brittain (as cited in Haegele & Hodge, 2016) supports this notion when citing that "many problems associated with disability may disappear if ... there is public policy that focusses on the removal of environmental barriers" (p. 197). In contrast, as the medical model seeks to fix a biological abnormality, placing responsibility of this dysfunction on the individual, there is no urgent need to remove barriers or change the environment as society is not responsible for the disability. This promotes the idea that society has minimal obligation to accommodate those with impairments. Because the medical model focusses on the 'within' factors, it usually ignores environmental determinants and how these barriers can affect an individual (Lindsay, 2003).

The social model continually attempts to change society by removing environmental barriers and this is another reason for how this model came to underpin inclusive education. Inclusive education emerged in relation to inclusion in society, both seeking to give equal opportunities to all, regardless of impairments (Terzi, 2014). Inclusion does not focus on the individual deficit that encourages 'fitting in', but rather supports a range of learning and physical

differences. Participation in school life is not restricted to limited access to curriculum or by physical barriers but instead inclusion aims to remove any disabling factor in an educational context (Armstrong, Armstrong & Spandagou, 2010; Naraian & Schlessinger, 2017; Oliver & Barnes, 2010). This is achieved by replacing stairs with ramps, incorporating accessible bathrooms, transport and sporting facilities into school plans, and improving curriculum design to support all students. Compared to special education institutions where students with impairments are separated from their typically developing peers, inclusive education allows for increasing participation and decreasing exclusion in all aspects of school life (Rees, 2017). The objective of inclusive education is to remove all barriers restricting access of students with impairments to equal education opportunities, which corresponds with social model beliefs of changing the environment to accommodate these individuals and allow for participation and access to the community.

Although the social model generates important considerations regarding the discourses of disability, the theoretical objectives compared to the actual practical application and concept is a little unrealistic. One current argument is that by severing the connection between impairment and disability the social model has “amputate[d] important dimensions of disabled people’s lives” (Beaudry, 2016, p. 212). The “impairment effect” (Thomas as cited in Reindal, 2010, p. 129) seems to be a negative consequence of the social model, because through establishing disability as a social phenomenon rather than a medical one, it fails to recognise the reality and lived experiences of an individual with impairments (Beaudry, 2016; Gallagher et al., 2014; Owens, 2015). These individuals have real limitations and these limitations may not have any relation to or in society at all. Some experience their impairment as an individual problem, not a social one, and others do not consider themselves a minority, therefore society has no responsibility for their disability, with Terzi (2004) commenting “it [the social model] downplays the importance of the relational nature of impairment, disability, and society” (Beaudry, 2016: p. 152).

The implications for the social model to disregard the actual lived impairment of an individual’s disability is ignorant and potentially dangerous to the individual or society. There are disabilities that, if not properly treated, can be life-threatening. This is not a societal limitation but a medical one. A child with a physical impairment should not be taught ‘society disables me’ as this places the blame of his impairment on a concept and this could potentially hinder the acceptance of his disability and future resilience overcoming its limitations. Owens (2015) noted that “if society did not create dependency then disability would disappear” (p. 386), but disability is not solely a construct of society, it is a realistic experience. Kliewer (as cited in Anastasiou & Kauffman, 2011) commented that “we do not believe a person has an intellectual disability; rather, the person is defined by others as having the condition” (p. 188). However, pretending something does not exist or changing the name or the contextual meaning to something less offensive does not change reality or make the situation disappear (Anastasiou & Kauffman, 2011). A child with limitations may not be the result of a disabling social barrier and while there is certainty that society does limit participation through disabling attitudes or environmental barriers, these restrictions should not be held accountable for creating all disability (Haegele & Hodge, 2016; Low, 2010). In its advocacy, the social model sometimes disregards the lived experience of the individuals it aims to benefit.

Furthermore, the concepts behind the medical model are still important in application. Rees (2017) discussed mothers of children with severe disabilities “[embracing] the social model in the sense that they believed social barriers served to create disability, yet at the same time they adhered to the medical model by continuing to seek within-child interventions to mitigate the impact of disability” (p. 32). The social model does not deny impairment exists but does not want them labelled as ‘disabilities’ (Beaudry, 2016). However, although categorisation and labelling is argued as a negative practice of the medical model, it is beneficial to the family, the teachers, other school staff and the community in general.

Labels in an early childhood inclusive classroom are useful for teachers so they can identify children who may need extra consideration, and an understanding of a child who may have a learning disorder will allow for the implementation of an effective early intervention program (Rees, 2017). A critique of the proponents of the social model towards the medical model is that medical professionals have the cognitive authority and maintain power over an individual with impairments. This notion relates back to the “impairment effect”, where the lived reality of the individual with an impairment is disregarded in favour of the social model philosophy, yet the authority and power of the medical profession is essential to the wellbeing and health of the individual. The doctor offers expert advice on treatment and care and offers other knowledge of benefit. A mother with a sick child would unlikely call a social model activist for information regarding appropriate treatment. Applied Behaviour Analysis therapy is successful using the medical model approach to professional power with the therapist (in power) helping eliminate behavioural problems in a child with autism (Shyman, 2016). The medical model is not an adversary to the social model but there should be a balance in application in real-life circumstances. Opposition to the medical model was a result of a person being not solely defined by their impairment, but these individuals still need some form of medical intervention for knowledge and assistance regarding their biological circumstance (Shakespeare & Watson as cited in Gallagher et al., 2014). The medical model still plays an important part in the lives of individuals with impairments and there should not be an overly suspicious attitude towards the medicalisation of disability (Beaudry, 2016; Low, 2010). The conceptualisation of the social model in conjunction with medical model application would have the medical profession look beyond the disability and consider the individual.

The concepts of the social model align with inclusive philosophy, which has made it the discourse that underpins inclusion policy. Inclusive education offers participation and acceptance for all, regardless of impairments, and seeks to change school environments and attitudes so all students have access to equal education. The social model also encourages acceptance for all, accepting the holistic individual, not just acknowledging the disability. In early childhood education, accepting and encouraging children in work and play, regardless of their impairments, facilitates their self-esteem and promotes their perception of themselves, subsequently affecting their learning life. However, although the social model has many positive ideologies, sometimes its advocacy does not account for the reality or lived experience of an individual with impairments. Furthermore, despite the social model’s opposition to the medical model, the medicalisation of disability still has practical value for individuals with impairments. In conclusion, although the social model seeks to break down attitudinal and environmental barriers to empower individuals with impairments, the medical model should not be disregarded completely. The medical model is not the enemy of disabled people but its concepts and practices benefit them in a different way. If the social and medical model combined their positive qualities, this encompassing model would be advantageous for these individuals and society as a whole.

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