Social representations of disability: Between models and persons. Debates and perspectives on the dynamics of social interactions

Abstract

This paper aims to describe and problematize the different models and approaches that attempt to understand disability throughout current history. People elaborate on these through their interactions as social subjects. In this sense, social representations about these models can maintain their validity, with greater or lesser legitimacy. Based on a qualitative review, we analyze the characteristics of the leading models and approaches proposed by various authors in the last two decades, linking them with social representations as discursive production and with the social practices of a given context that is simultaneously constructed. We conclude that this critical review leads to a rethink of social representations, professional practices, and discursive crossings from the different models and approaches to disability. Finally, we reflect on how, when presented as hegemonic and totalizing representations, models can deprive the subject with a disability of agency, preventing him/her/them from critically reflecting, rethinking, and re-presenting him/her/them, as well as from making decisions based on his/her subjectivity expressed in everyday life.

Keywords

Persons with disabilities, models, social representations.

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1. Introduction

> "Social representations are a particular modality of knowledge and elaborated by the social subject, which is situated in a particular time and space"
> (Moscovici, 1979, p. 17).

> "Social representation is, simultaneously,
> constituted and constituent thought"
> (Ibáñez, 1988, p. 36).

> "The social and the individual are two mutually interdependent
> components of social representations,
> which are also fundamental features of institutionalized
> sociocultural phenomena, such as scientific paradigms"
> (Marková, 1996, p. 163).

Just as social representations are situated in a particular time and space (Moscovici, 2015), it is also deemed convenient to introduce this work based on three definitions of social representations, a term that is frequently used without considering its defining characteristics and which are fundamental to understand how models are elaborated by people in interactions, as social subjects, guiding their practices and discourses. Thus, scientific models[1] -abstract representations (conceptual, graphic, among others) of phenomena, systems, or processes- seek to explain, describe, and distinguish the dimensions of analysis of complex realities constructed in the processes of social interaction. In this sense, Moscovici & Heawstone (1986) propose social representations as "implicit theories" in the sense that they serve to describe, classify, and explain through attribution schemes.

In traditional epistemology, "models become epistemically relevant to the extent that they manage to represent that phenomenon" (Accorinti & Gonzalez, 2016, p. 22). In this aspect, Díaz Velázquez (2009, p. 2), following Khun, distinguishes the term model as "a simplifying representation of reality in which only the most considered and defining relationships of the phenomenon are highlighted". Thus, the approaches that emerge within the same model would represent —from this perspective— different approaches, different contributions framed in the general principles, and shared meanings supported by the reference model. These, in turn, question and seek to emancipate themselves from the hegemonic representations that a given model holds and imprints on practices and discourses. Thus, the approaches would represent movements in tension concerning the models' central core and account for the dynamics within the processes of social construction. In this way, the meanings of social representations are not neutral, given that they are socially constructed and shaped by the singularity of the subjects and the place they occupy in the world where experience, history, and social context intervene (Araya Umaña, 2002). In this sense, social representations are always situated.

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[1] We agree with Diaz Velázquez (2009), who points out the terminological confusion between model and paradigm in the approach to this topic, either as synonyms or as dependent on each other, understanding the model as part of the paradigm. In this article, the term "model" is adopted to emphasize a way of knowing from an exemplary pattern to be reproduced, which can become an obstacle, depriving the subject of disability of agency. Thus, these models can be reconstructed historically and analyzed in the local contexts in which they are used, allowing them to highlight their reappropriations, conflicts, and transformations.

Each model and approach is generated from the structural and hegemonic characteristics in specific historical moments; models and approaches that "have been overcoming, overlapping and nuanced from the problematization of subjects, collectives or organizations, that is, they are not universal or mutually exclusive, but coexist, dialogue, tension, and rework" (Campero et al., 2019, p. 22). Berghs et al. (2016) suggest that the evolution of the debates shows how models of disability interact with each other[2].

The first authors who study this topic (Aguado Díaz, 1995; Casado Pérez, 1991; Puig de la Bellacasa, 1990), as well as more recent authors (Berghs et al., 2016; Campagno 2019; Devenney, 2004; Mareño Sempertegui, 2012; Mareño Sempertegui & Masuero, 2010; Palacios, 2008; Pérez & Chhabra, 2019; Vargas Dengo, 2012 and Velarde Lizama, 2012) give different names to the models of disability from the different theoretical perspectives they support.

Thus, to dialogue with the objectives of this work, to describe and problematize the different models and approaches that attempt to understand disability throughout recent history, the models of dispensation, medical, social, and biopsychosocial and human rights are adopted, considering that they continue to be reworked by social actors in the present. Likewise, the approaches comprising each model that account for the emancipatory movements toward the construction of new models and approaches are distinguished in this review, which does not pretend to be historical but illustrative, citing specific representative facts to the existing tensions within the "models".

2. Methods

This scoping review included the exploration and identification of studies on models, approaches, and social representations of disability located in the literature over the last twenty years, which allow us to describe the main characteristics and controversies raised between models and approaches to disability, as well as to glimpse the scope of the definition of disability that underlies the practices and discourses that are continuously elaborated by social subjects in their interactions.

The search for studies was carried out using the databases Redalyc, Scielo, Dialnet and the Google Scholar meta-search engine. Initially, the search was carried out through these media using keywords: "models of disability," "approach to disability," and "social representations of disability," which yielded a profuse production in the period between 2002-2022. Inclusion criteria were applied (articles and research with a predominantly qualitative approach, without a specific approach by type of disability or area and presenting potential tensions and debates following the proposed objective). In the second stage, based on the articles found, the snowball technique was used within the bibliographic references of each work. Thus, 56 scientific articles, 25 book chapters, and seven research theses were selected. This selection does not pretend to ignore the existence of other research on the subject. Finally, a saturation level was reached in the finding of new works. When different works were no longer found when they tended to be repeated, they were analyzed.

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[2] Berghs et al. (2016) also emphasize that it is important to distinguish "ideal models in order to understand the (potential) connection of different models to public health research and interventions" (p. 26).

3. Results and discussion

We will now describe the results of the models chosen for this work, entering the corresponding discussion to articulate the different frames dialogically. This design collaborates in favoring a critical and concatenated reading. Thus, we will mention each of the models, briefly review them, and discuss some of their aspects, emphasizing that the discussion concerning them is ongoing. Nevertheless, given the limitations imposed by the article, we choose those aspects considered most relevant for this paper.

3.1. Dispensing model[3]

Since the beginning of human social life, various societies have established a hierarchy of care, where elimination, abandonment, and marginalization have been ways of treating people with some deficiency or deformity. Palacios (2008) suggests two essential characteristics for this model, which he proposes to call: "the religious justification of disability and the consideration that the person with disability has nothing to contribute to the community" (p. 37). The strong connotation of the model's name continues to represent the exclusion of the person with a disability to this day. However, it has not been presented so categorically in the origins of this model. Although ancient Greece was the foundation of Western civilization and promoter of the affirmation of rights and dignity of its citizenship, these rights did not reach all people. Neither women nor foreigners, let alone enslaved people, were considered citizens.

On the other hand, the obsession with beauty that characterized Ancient Greece - reflected in the Arts and philosophy of Greek culture - left little room for defect, weakness, or imperfection, which inexorably marked their destiny (Devenney, 2004). Thus, it became a common practice that newborns with deficiencies were eliminated on the iconic Mount Taigeto in Sparta in Ancient Greece. In turn, the author (2004) exemplifies the attitude towards people with disabilities with the famous story by Sophocles, which links Oedipus' blindness with divine punishment. However, other authors exalt blindness as a form of "inner vision" associated with introspection in Ancient Greece. On the other hand, it is also highlighted how the emperor Claudius was distinguished for his intelligence and wisdom in the Roman Empire beyond his limitations in oral communication. Likewise, Devenney (2004) states that the numerous efforts to develop treatments for the cure of acquired deficiencies made by both Greeks and Romans are ironic: Aristotle with his studies on deafness; Galen and Hippocrates seeking to cure epilepsy; or the Romans introducing hydrotherapy for the treatment of arthritis. Thus, the author above concludes that the beginnings of the medical model can be observed in this period, where disability is something to be cured or treated, especially for those deficiencies acquired in wars, which implied another social recognition concerning birth deficiencies that were not accepted within a society that worshiped health and physical beauty (Palacios, 2008).

On the other hand, the Abrahamic religious traditions (Muslim, Jewish, and Christian), the basis of Western morals and values, perceived the deficiency as the result of something diabolical, for which they were excluded from religious rituals. Leprosy is a clear example of a diseases, which since ancient times was considered a disease of sinners and socially rejected, where people suffering from it were forced to live in isolated colonies and where contagion and rejection were strongly associated with carriers of the disease.

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[3] Also called the traditional model (Aguado Díaz, 1995; Puig de la Bellacasa, 1990; Casado Pérez, 1991).

Subsequently, Palacios (2008) states that because of the Black Death in the late Middle Ages and added to the accusations of witchcraft, people with disabilities will also be associated with contagion and poverty, turning marginalization into an actual exclusion[4]. In this sense, the social representations of disability associated with curses, divine punishment, and begging also stand out (Díaz & Rojas Malpica, 2006).

In the 17th century, severely handicapped people were admitted to hospices (most early hospices were built near churches) run by monks and nuns, according to Devenney (2004). In general, these people ended up being abandoned by their families. The author mentioned above states that this situation of sick, abandoned people or people under the protection of religious orders represented an essential reason for the community to make an economic contribution to them. During this period, social representations of disability linked to charity towards people with disabilities as objects of care emerged (Devenney, 2004; Figari & Figari, 2005). However, there also emerge social representations of disability associated with mockery and fun (Díaz & Rojas Malpica, 2006; Figari, 2018), linked to a body considered "disproportional" and "monstrous" concerning a measure of "normal". In this sense, if not abandoned in those asylum institutions, many people with physical malformations or short stature could eventually occupy a place in the Court as jesters of the king (Palacios, 2008). All the representations described above can be seen reflected in medieval and Renaissance art and literature.

In the middle of the eighteenth century, a reconfiguration of the subject as a work tool took place because of the Industrial Revolution, and disability was established as a social problem for the production and creation of wealth in a capitalist society. Beyond workshops and factories, new ways of conceiving disability associated with disability, unproductivity, and poverty are generated (Díaz & Rojas Malpica, 2006). From the end of the 18th century to the beginning of the 19th century, there was a transition from charity to beneficence aimed at those unable to earn a living (Palacios, 2008).

At the end of the 19th century, with the emergence of social Darwinism and eugenic movements, science was used to justify that any physical or mental deficiency was a threat to society. In this sense, the iconic image of the ship of the insane[5] that Foucault (1976) reminds us of characterizes this voyage without a destination or port where to dock: an endless journey where the insane had to be far away from everyone. Undoubtedly, the foundations of asylum logic were uncritically extended throughout the Modern Age and even into the Contemporary Age when the anti-psychiatry movements emerged at the end of the 1960s[6].

Although Ferreira (2010) states that the model of dispensation is a "model that has been definitively overcome" (p. 52), it is agreed with Campagno[7] (2019) that it exceeds a given historical period since it can be observed today through practices that are more invisible because they are scientifically approved, such as eugenic treatments[8] (Crow, 1996; López Mainieri, 2010), the suggestion of abortion practices when identifying that the fetus has a genetic syndrome, such as in the case of Down syndrome (Jones, 2020) or with the refusal to provide respiratory assistance to people with disabilities in the recent context of the COVID-19 pandemic in

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[4] See Palacios, 2008, pp. 54-66.

[5] "The ship of fools" is a work by the Flemish painter Jheronimus van Aken "El Bosco" (1500), which depicts the pilgrimage of men and women who were not "in their right mind" and traveled the sea aimlessly.

[6] Added to the most recent mental health laws —between the end of the 20th century and the beginning of the 21st century— which not only establish a regulatory framework from a human rights approach, guaranteeing other modes and modalities of care in the new outpatient or community services and avoiding reinstitutionalizations; but also, the growing involvement of users in the new services; favoring participation and decision making (Hernández Monsalve, 2017).

[7] Campagno (2019) distinguishes between eugenics, marginalization and exclusion.

[8] Eugenics is a procedure that allows genetic manipulation; it has been legalized in several countries in response to scientific advances and the search for mechanisms to reduce the presence of pathologies and diseases in human beings.

some health care centers. Likewise, in recent research (Figari et al., 2023), a person with a disability presents a self-definition of the group: "We are nobody in the face of the indifference of the other (...)", when referring to the barriers experienced, without feeling like a full member of the community. In this sense, the following section characterizes the medical model from the perspective of disability models.

3.2. Medical model[9]

Barbosa et al. (2019) place the beginning of the medical model "in the late eighteenth and early nineteenth centuries, mainly in France, where a new medical conception focused on the humanization of the disabled patient, especially the mentally ill, emerged" (p. 115); while other authors place its origin in the early twentieth century, following the First World War, along with the introduction of the first legislations around social security (Palacios, 2008; Velarde Lizama, 2012).

The idea of disability underwent a paradigm shift as it began to be considered an individual problem caused by a disease, which requires medical care in the form of individual treatment and rehabilitation to integrate the subject into society.

Thus, the medical model based on etiology will diagnose diseases and disorders in which disability will be related to deficiencies of body structures or functions, thought from the disease and not from health (OMS, 2001). Diagnosis and deficit appear as labels framed in various classifications (Joly, 2007), constituting a "personal tragedy" in Oliver's terms (1998). Under the justification of a medical diagnosis and a legal certificate, disability will later emerge not only as an individual problem but also as an objective one (de Iducibus, 2006), as can later be seen in the International Classification of Impairments, Disabilities and Handicaps (ICIDH) (OMS, 1980). Although this classification represented a model that surpassed the exclusively medical vision by understanding the consequences of the disease (Egea García & Sarabia Sánchez, 2004), the assumption of biomedical normality underlies its conceptual framework. It should be noted that the definitions included in the classification above emerge under the principle of normalization, where the criterion of "as normal as possible"[10] framed international and national legislations and the first integration approaches for people with disabilities in different areas: education, rehabilitation, labor, among others (Figari and Figari, 2005). In this sense, reference is made to the fact that this model focused on the individual puts the axis on the body, its deficiencies, and the medical assumption of biomedical normality, without considering the sociocultural circumstances (Berghs et al., 2016; Mareño Sempertegui & Masuero, 2010; Ferreira, 2007; Vargas Dengo, 2012). Thus, social representations of disability associated with the medical model are linked to diagnosis, disease, deficiency, individual attributes, medicalization, rehabilitation, and normalization (Barnes, 2003; Brogna, 2009; Berghs et al., 2016; Devenney, 2004; Suárez et al., 2011; Vargas Dengo, 2012).

On the other hand, Velarde Lizama (2012) notes that the detractors of the rehabilitation model have seen it as an instance of oppression (Barnes et al., 2010), alleging that the person with a disability is stigmatized by the physician with a diagnosis of disease and that social integration is subordinated to rehabilitation. Sometimes,

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[9] Other authors have called it the "hegemonic medical model", "individual" or "rehabilitative model" (Puig de la Bellacasa, 1990; Casado Pérez, 1991), emphasizing that medical-professional intervention prevails over the subject's demand (Egea García & Sarabia Sánchez, 2004).

[10] O'Brien (1999) states that Bank Mikkelsen first proposed the principle of normalization in the late 1950s for people with intellectual disabilities. Later, Wolfensberger (1975) expanded the concept and extended the principle to all people with disabilities, as did Warnock (1978), who applied it in the educational field. A critical reading of this principle should be considered in the historical context in which it was formulated.

the gaze not only of professionals but also of the person with disabilities themselves focuses on the individual, pathologized, and medicalized condition, as on the processing of the disability certificate, where biomedical essentialism can take place/body without interpellation by the subject about some criterion of normality or contextual factors at play (Figari, 2018; 2019). Nevertheless, and despite the criticisms to which this model may be subjected given its hegemonic and exclusive imposition, positive aspects can be highlighted, such as early and timely habilitation/rehabilitation care and treatment (Bregáin, 2021; Menéndez, 2020) and "the possibility of minimizing disabling consequences through intensive treatments" (REDI, 2011, p. 52) in function of a social and labor integration in the community (Figari & Figari, 2005; Velarde Lizama, 2012). In this sense, Crow (1996) states that the implications of impairment must be recognized, that "the experience of impairment is not always irrelevant, neutral or positive (...)" and that, although "disability remains our first concern, impairment lives among us" (p. 15).

3.3. Social model

In the 1970s, groups of people with disabilities began to organize in the United States, Canada and Europe, demanding autonomy and independent living. While in the United States of America, this movement began with the emblematic protest led by Ed Roberts in the face of access barriers to the University of Berkeley, California, and with the subsequent creation of the movement and centers for independent living; in the Anglo-Saxon world, Disability studies[11] initiated the systematization of a heterogeneous set of critical studies on disability (Ferrante & Dukuen, 2017). In the United Kingdom, the UPIAS (Union of People with Physical Disabilities Against Segregation) proposed a set of fundamental principles where disability is understood as a specific form of oppression generated by barriers, (dis)ability, and social exclusion of people with disabilities in their participation in everyday life activities (Barnes et al., 1997, 2010; Barton, 1998; Marks, 1997; Oliver, 1998). Berghs et al. (2016) posit that this interpretation has changed over time regarding the needs of people with disabilities according to activism and social change[12]. From the movements of struggle and resistance, social representations of disability appear associated with antithetical pairs, classic dualisms in social sciences, such as autonomy/dependence, capabilities/disabilities, self-determination/social oppression, integration/discrimination, and accessibility/barriers (Suárez et al., 2011; Díaz & Rojas Malpica, 2006; de Queiroz Brito et al., 2015; Rodríguez Rodríguez et al., 2017).

However, another historical milestone, such as the anti-psychiatry movement, is worth mentioning, which contributes to the social model's construction. This movement began at the end of the 1960s and emerged as resistance to the logic of asylum and electroshock treatment, with criticism of the total institution and institutionalization (Cooper, 1972; Szasz, 1976), diagnostic labeling, and stigmatization (Goffman, 1970). In this sense, Ferreira (2010) states:

> The origin of this social model must be geographically located in the United States and England, where people with disabilities themselves took the initiative and promoted their political changes; in the United States for educational issues, and England, demanding their deinstitutionalization. (p. 54).

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[11] Disability studies is an interdisciplinary area that addresses the social, cultural, and political factors that construct disability as a social problem.
[12] In the 1990s, this model was called "personal autonomy" (Aguado Díaz, 1995; Puig de la Bellacasa, 1990 and Casado Pérez, 1991), characterized by the principles of equal opportunities and universal design, the main objective being independent living.

In the 1980s, in contrast to the hegemonic and individual medical conception, the social model of disability gained relevance (Oliver, 2008; Shakespeare, 2010), a model that maintains that the social environment generates disability in "people with impairments". Within the social model, several approaches can be found which, as previously mentioned, represent different contributions that, while remaining within the framework of the fundamental principles of the model of reference, question and seek to emancipate themselves from the hegemonic model, bringing new meanings to the practices and discourses on the social model.

3.3.1. Cultural approach

Pérez & Chhabra (2019) call it a cultural "model" and distinguish that it is based on a conception of disability as a minority social identity. Thus, impairment and disability are categories that construct culture and are nourished by it as sociocultural entities (Waldschmidt, cited by Pérez & Chhabra, 2019, p. 19). From this perspective, disability can be denaturalized, that is, no longer conceived and approached as a strictly medical problem, but understood and studied as a social and political category to understand the dominant forms of health, functioning and normality. The result of (de)normalization practices in the social category of disability is investigated (Pérez Dalmeda, 2017; Oliver, 1998; Rosato & Angelino, 2009). From this constructivist and discursive perspective, the analysis of inclusion/exclusion and stigmatization/acceptance, as well as themes of experience and identity, play a preponderant role in cultural relativity and historical contingency (Ferrante & Ferreira, 2008; Ferreira, 2007, 2008, 2009; Ferrante & Venturiello, 2014; Joly, 2007; Mareño Sempertergui & Masuero, 2010; Reeve, 2012; Rosato & Angelino, 2009; Soto Builes & Vasco, 2008; Goodley et al., 2017; Pérez & Chhabra, 2019). Many authors ascribe to a sociocritical perspective (Vargas Dengo, 2012) and a critical-relational approach to disability. Thus, Berghs et al. (2016) highlight that critical disability studies propose a significant debate about (dis)ableism (discrimination against non-normative people according to biomedical criteria). Berghs et al. (2016) highlight the emergence of other lines, such as psychoemotional (dis)ableism (Reeve, 2004; Thomas, 1999) and intersectionality with chronic illness and gender (Thomas, 2006). Pérez & Chhabra (2019) and Verdugo Alonso (2001) highlight among the strengths of this approach that many activists were involved in academic life and fought for the rights and equal participation of people with disabilities in a specific field of study. On the other hand, Skliar (2003) warns that it should not be thought that there is only one type of Disability studies but that these constitute a field with different traditions or theoretical perspectives, which still present discussions and contrasts. In this sense, Shakespeare (2010) states that, at times, cultural studies "seem much more interested in texts and discourse than in the lives of people with disabilities" (cited by Pérez & Chhabra, 2019, p. 20).

3.3.2. Relational approach

As mentioned above, and from the social model, contextual factors become relevant to understanding the diversity of disability situations. Goodley et al. (2017) state that if the social model understood that disability was only caused by the environment, the Scandinavian[13] or relational model emphasizes the interaction between the individual and the environment where he/she develops his/her activities, and this represents the central concept. In this sense, Berghs et al. (2016) emphasize that a more dynamic and situational

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[13] It should be noted that this approach does not distinguish between disability and impairment because there is no such distinction in the Nordic languages (Goodley, 2017).

dimension of disability is imprinted, as well as the capabilities of the person that unfold according to social contexts. Thus, Fougeyrollas et al. (2019), Brogna (2009, 2012) and Cortéz Reyes et al. (2013) state that disability is a relational construction between society and a subject and that it takes shape in a situational, dynamic, and interactive space, between a subject and the surrounding community. Brogna (2012) states that disadvantage increases or decreases depending on the social (and economic) context.

As a criticism of this approach, Goodley et al. (2017) point out that emphasis is placed on the positive influence of Scandinavian social services, linking them to a welfare state, to the detriment of other contexts, as well as that this model would not prove as representative for associations of people with disabilities (cited by Perez & Chhabra, 2019, p. 17) and the community empowerment it entails.

3.3.3. Functional diversity approach

Other authors, such as Palacios & Romañach (2006) and Mareño Sempertegui & Mausero (2010) refer to another perspective based on the condition of human diversity from the social model. Guzmán et al.[14] (2010) propose the diversity model, understanding it as an evolution of the social model, together with a terminological change, the acceptance of functional diversity as part of the enriching human diversity and achieving full dignity in functional diversity. From this approach, the term "person with functional diversity" would provide a positive connotation as a name for a group that fights against discrimination, avoiding the negative connotation of nominating themselves from their condition of disability (Figari, 2018). It is postulated that the proposed term overcomes the word "disability" proposed by the social model, which emphasizes "ableism"[15]. Thus, Palacios & Romañach (2006) highlight that this model is enriched by the proposal of Toboso-Martín & Guzmán Castillo (2009) about the incorporation of the capabilities and functioning approach and the reintroduction of the body through bioethics (de Pena & Silva, 2017), as a tool for change. Subsequently, Palacios (2020) postulates that the functional diversity model represents a new wave of the social model in terms of "the construction of an identity of people with disabilities from a transdisciplinary view and from the movement itself, which transcends the condition as biological, natural and deficient" (p. 42).

It is considered that this terminological proposal, with great acceptance in the activism of people with disabilities for their self-denomination as a group, only provides a new comprehensive and inclusive term of how to situate and name themselves within the diversity of the human condition.

Among the criticisms of this approach to the social model, it is highlighted that the denomination alludes to "the singularity of the functioning of a body," sustaining a presupposition of "a certain condition of normality to which the body deviates" (Ferreira, 2010, p. 59), and that it pretends to be a conceptual synthesis of the term "disability" (Rodríguez Díaz & Ferreira, 2010). Similarly, Brogna (2012) states that the concept of disability remains connoted, highlighting the contradiction of using a diagnosis to name a social subject and that "perhaps there is some term to be invented, to be resemanticized" (p. 38). Mareño Sempertegui & Masuero (2010) suggest that the very concept of diversity, as an inherent and constitutive characteristic of the human condition, would not need to be adjectivized under the concept of "functional" since this term

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[14] Romañach explains that "although the correct term would be PDFD - person discriminated against due to functional diversity - for the economy of language, the term "person with functional diversity" is used (quoted in Brogna, 2012, p. 40). From the Independent Living Movement Forum platform created in Spain in 2001, following other international initiatives, this term is created in line with this movement—more information: http://forovidaindependiente.org/.

[15] Subsequently, their representatives recognized that they were referring to impairment, not disability (Palacios, 2020, p. 37).

would not provide any distinction under the characteristics proposed by those who propose it (dignity, decision-making, and accessibility).

Figari (2018) notes that this nominalist tension persists among the denominations proposed by different researchers and among the self-denominations that the subjects choose or ascribe beyond the scientific discourse and the model adopted. In such a sense, Orbaiz (2017), in a TED presentation, states: “We are people with disabilities... people”.

3.3.4. Other contributions for a critical review of the social model

Corker, in Ferreira (2009) states that:

> In the same way that the medical diagnosis and the referral of disability to a physiological impairment homogenizes, in social terms, a group by its mere ascription to the condition of chronically ill; in the same way, from the social model, an analogous homogenization is imposed - to a large extent - from the other plane of the dichotomy, in which both models are installed, by identifying any singular experience of disability as “social oppression.” (quoted in Ferreira, 2009, p. 9).

We agree with Ferrante & Venturiello (2014), Ferreira (2008), Hughes & Paterson (2008), Silberkasten (2014), Shakespeare & Watson (2001), who have pointed out the “forgetting” of the body by the theory of disability produced by the social model. Also agreeing with that position, Berghs et al. (2016) question disability understood as a positive identity since it is not enough to represent particular groups, such as people with deafness, neurodiverse, or war veterans, who may not consider themselves as people with disabilities.

On the other hand, Mareño Sempertegui & Masuero (2010) suggest three critical limitations of the social model: first, not incorporating impairments in the analysis of the phenomenon, underestimating their impact on the lives of people with disabilities; second, assuming a homogenization of the population, ignoring the existing heterogeneities and, finally, sustaining the supposed biomedical normality characteristic of the medicalized model. Subsequently, Campero & Ferrante (2019) raise a necessary debate in the social sciences about the scope of the social model as “a closed package”.

Contextualizing it in its origins and restoring the category impairment as part of the problematization of what disability comprises and subtracting its negative connotation, in this way, the authors above propose to understand it as “an organic particularity without any negative connotation” (Campero & Ferrante, 2019, p. 128). Similarly, Crow (1996) raises “the need to find a way to integrate impairment” as part of the experience of disability (p. 4). Goodley (2001) and Shakespeare & Watson (2001) question this difference between impairment and disability. The first author highlights that this distinction reinforces the body-mind dualism in the biomedical model and the other two, referring to the social model as obsolete. Also, Campero and Ferrante (2019) propose a debate about understanding disability as a form of oppression that sustains this model, mechanically homologizing it to the conditions of existence of an ethnic minority or a social class (p. 128). Palacios (2020) and Méndez (2016) refer to the need to include an intersectional view in the social model, which enables the construction of a complex identity without standardizing the demands and needs of people with disabilities. This debate is necessary to avoid falling into reductionism and stumbling over the same naturalizations attributed to the hegemonic medical model.

4. Biopsychosocial model

Under the activism of the disability movements, the World Health Organization family classifications are also influenced by the social model. Thus, a new definition of disability is proposed in the International Classification of Functioning, Disability and Health (ICF):

> […] is not an individual attribute but a complicated set of conditions, many created by the social environment. Therefore, managing the problem requires social action, and it is the collective responsibility of society to make the necessary modifications for the full participation of people with disabilities in all areas of social life. The issue is then situated at the level of attitudes and ideologies and requires social changes, which are transformed at the political level into a human rights issue. According to this model, disability becomes a political issue (OMS, 2001, p. 18).

Although the ICF (OMS, 2001) pronounces and ascribes to the social model (p. 18) and incorporates the terminology in its conceptual framework, its methodological application responds to a biopsychosocial model. The ICF, from the beginning of its development, is pronounced by a biopsychosocial approach (Aguado Díaz, 1995; Mareño Sempertegui & Masuero, 2010; Pérez & Chhabra, 2019), seeking to overcome the biomedical perspective prevailing so far (Egea García & Sarabia Sánchez, 2004). According to Cortés Reyes et al. (2013), the three-dimensionality of the concept of health coincides with the biopsychosocial approach to disability proposed by the ICF, which confirms that disability is a dynamic, relational, and interactive situation whose nature and magnitude will depend on the conditions of the environment.

Unlike the International Classification of Impairments, Disabilities and Handicaps (ICIDH), which understood disability as the "consequences of the disease," the ICF becomes a "classification of health components," where the functioning-disability continuum is included. It can be seen that three levels of consequences of the disease are not stated. However, there is talk of functioning (as a generic term to designate all bodily functions and structures, the capacity to carry out activities, and the possibility of human social participation), disability (likewise, as a generic term that includes deficiencies in bodily functions and structures, limitations in the capacity to carry out activities and restrictions in human social participation) and health (as the vital element that relates the two previous ones), in dynamic interaction with contextual factors (environmental and personal). It also introduces two qualifiers in environmental factors: Facilitators and barriers, which were quickly incorporated by people with disabilities and professionals to describe the effect of environmental factors on a person's performance in daily life.

From this conceptual framework, disability is understood as part of a health condition. It indicates the negative aspects of the interaction between an individual's health condition and contextual factors, a definition included in the one proposed by the Convention on the Rights of Persons with Disabilities (UN, 2006) (from now on, the Convention).

Among the strengths of the ICF and related instruments, it is highlighted that they allow for exploring the prevalence of disability, measuring functioning and disability, and allowing data comparison (Berghs et al., 2016). Also, its terminology and operational definitions have facilitated its dissemination and application with the production of numerous research worldwide in different contexts, especially in rehabilitation (Berghs et al., 2016).

Figari (2018) emphasizes that its objective is to describe the health condition of an individual in dynamic interaction with contextual factors and not to classify individuals, an objective that is important to highlight given the change it imprints and attempts to achieve. However, she adds, it is essential to recognize the overlap between ICD-10 (OPS, 1995) and ICF (OMS, 2001). Both classifications begin with body systems. Impairments refer to the body structures and functions that are usually part of the "disease process" and are therefore also used in ICD-10. The difference is that the ICD-10 system uses impairments (such as signs and symptoms) as parts of a whole that make up a "disease" or, sometimes, as reasons for contacting health services. The ICF system uses impairments as problems of body functions and structures associated with health conditions (OMS, 2001, p. 4).

From this perspective, the controversies raised by some researchers (Ferreira, 2010; Mareño Sempertegui & Masuero, 2010; Rodríguez Díaz & Ferreira, 2010; Rosato & Angelino, 2009) regarding the term "health condition," which they associate with a criterion of normality proposed by the definitions of the International Classification of Impairments, Disabilities and Handicaps (OMS, 1980), can be understood. Thus, Rodríguez Díaz & Ferreira (2010) state that the ICF "expresses the current validity of the medical-rehabilitative model" (p. 300). At the same time, Figari (2018) states that the conceptual framework proposed by the ICF does not correspond to the medical-rehabilitative model, given that it comprises the description of positive and negative aspects of the functioning-disability process in dynamic interaction with contextual factors and not its diagnosis. However, the author above also highlights that the joint application with ICD-10 in the evaluation for the certification of disability in Argentina, together with the request for studies and medical reports required by law, sometimes reflects that the medical approach maintains its predominance over the biopsychosocial approach proposed by the ICF conceptual framework. From this situation, with the possibility that the person with a disability is the bearer of a certificate that grants a name and a social identity under the condition of certified disability, other social representations associated with the existence of being a subject/object of classification are also generated (Figari, 2018). Vidarte Claros & Avendaño (2017) highlight the social representations of functioning, disability, person, and context associated with this model.

Another limitation lies in the very term "biopsychosocial". Not only because of the integration of antagonistic models, as proposed by Mareño Sempertegui & Masuero (2010), but also because it pretends to include every possible situation of disability, representing a totalizing description and, therefore, simplified and plain. In this sense, another criticism regarding the ICF is linked to the lack of description of personal factors and being able to reflect on what living with their disability condition implies for the person with a disability (Berghs et al., 2016). This experience is not always contemplated and integrated into the application of this model, both in individual and social terms. As well as when it is understood in exclusively classificatory terms, excluding the history of "decided singularities".

As proposed by Lewkowicz (2006) concerning diagnostic classifications in general, the subject participates by contributing his or her own unique experience, making decisions, and supplementing this coding in an open system of instituting experiences. In short, this model does not account for the subjective aspects of the dynamic interrelationship of a disability situation.

5. Human rights model

Berghs et al. (2016) state that, since 2006, civil and political rights debates began around the Convention, and the activists and researchers involved in it advocated for a human rights model. In this regard, Quinn et al. (2002) and Rioux & Carbert (2003) indicate that human rights are based on recognizing human dignity and that social, economic, cultural, political, and civic rights are guaranteed as inherent to the human condition. Under this denomination, the existing tension between the medical and social models seems to be overcome when they are reworked under the perspective of human rights and embodied in the framework of the Convention on the Rights of Persons with Disabilities, from where the person with disabilities is re-presented and dis-covered as a subject of rights (Velarde Lizama, 2012; Ripa, 2014; Figari, 2018, 2022).

On the other hand, Palacios et al. (2021) emphasize that the functional diversity model is based on the framework of human rights and bioethics, which constitutes an essential tool to achieve the dignity of people who are discriminated against because of their disability. However, Degener, in Pérez & Chhabra (2019, p. 18), states that "by emphasizing dignity as an inherent characteristic of the human being and impairment as part of human diversity, the human rights model is opposed to the social model"; a statement that contrasts with what was raised by the previously cited authors and later taken up by Palacios (2020). The cited author discusses that when the existence of a "new model of human rights" enshrined in the Convention is affirmed, it represents an "approach" to human rights, which considers the deep bridges between the social model and the values that underpin human rights. While the author acknowledges that the human rights "model" claims to encompass all identities and intersections, she warns against the risk of invisibilizing them. Thus, she argues "that the human rights 'approach' (not model) should include the social model, instead of pretending to overcome it, because overcoming it may imply making it invisible" (Palacios, 2020, p. 34). Other authors, such as Jiménez Lara (2021), Parra Dussan, and Palacios Sanabria (2007), also categorize it as a rights approach.

According to Berghs et al. (2016), inclusion forms the central core of the human rights model. It is linked to the rights perspective with concepts such as human development and capabilities (Fougeyrollas et al., 2019).

On the other hand, this model has implications for disability research. In this sense, Hunphries et al. (2000) propose that people with disabilities should be promoters and active participants in the research processes (cited by Puyalto Rovira, 2016, p. 168). Similarly, Arstein-Kerslake et al. (2020) propose that research designs should be initiated, oriented, and conducted by persons with disabilities, providing answers to approaches related to the human rights outlined in the Convention. They also point out that research results should be returned as input to the community of persons with disabilities, guaranteeing their transmission and contemplating their accessible format.

We agree with Ripa (2014), who points out that for people with disabilities, this human rights discourse is crucial, which "brings a novelty in identity recognition by being seen as a subject of rights and this new way of seeing oneself produces an attitude of dignity of such importance that we are just beginning to glimpse its possibilities" (p. 75). Thus, the social representations of this model are associated with inclusion, equity, accessibility, and dignity, as the person with a disability is considered a subject of rights (Córdoba-Andrade et al., 2021).

Thus, Brogna (2019) poses that "it is evident that the node of meaning woven around human rights challenges in the polyphony it evokes" (p. 36), but also warns that "narratives of rights by no means assure the subject of rights the possibility of enjoying and exercising them" (p. 34).

Finally, Berghs et al. (2016) point out that, although this model results in a framework and a way of defending the rights of persons with disabilities, it can become a form of protection and safeguarding of rights with a paternalistic tone. The authors add that "despite the Convention, there is a risk that disability will be framed as an individual problem" (p. 35), to the detriment of a collective approach. Therefore, Atkin et al. (2023) argue that the institutionalization of this framework of rights can generate "normative expectations"; that is, disability becomes a predefined "other" rather than a contingent circumstance.

6. Final considerations

Each model and approach that has been described, contextualized and problematized shows the social construction of disability and the models, approaches and social representations that underlie and maintain their validity, guiding practices and discourses. Thus, antagonistic visions and representations can coexist without raising tensions, even when each of these visions holds a position of disability different from the other (Brogna, 2009; Campagno, 2019). It is agreed with Vargas Dengo (2012) that the identification of approaches and models from the different theoretical perspectives that frame them has important implications for research on disability, since they make it possible to clarify the epistemological positioning in terms of approach to knowledge and in practical applications in the life of this group. In this sense, it is observed how social representations that emerge in a historical context are re-signified in other contexts, updated in the social interaction of the present, without losing the validity of the past and remaining active in the field (Brogna, 2009). Thus, as Puget (2015) writes: "becoming a social subject implies going through situations of imposition and choice, in everyday life and every relational context" (p. 87), proposing to think the presentation that is not reduced to mere representation.

Tensions and disputes between different models and actors who try to impose their way of understanding disability as the only possible answer to a complex problem through totalizing categories belonging to a closed and immutable system are manifested among people with disabilities and professional practices. Ways of printing models that do not reflect the mobility and flexibility of social situations where the "dilemma of difference" is presented and where disability can be recognized, transformed or denied according to the contextual circumstances in which this is activated" (Slater, 2015; Pérez Acevedo, 2012), being dynamic and relational situations where each person with disabilities makes their decisions (Figari, 2018). Thus, the appropriation of a model without questioning can hinder some dimensions of the unique situation of disability experienced by the person, closing paths to produce new meanings and transformative potentialities for their daily lives.

This overview of the social representations underlying each model of disability and its scope is intended to provide a critical and reflective look at the practices and professional discourses involved and to highlight that, without the participation of the different voices of people with disabilities in the construction of specific models or approaches that are proposed, these may be abstract and empty in terms of the content and practices they are intended to embody. It will be the transformations in terms of inclusion and accessibility achieved in the lives of persons with disabilities that will tell us whether the human rights model has indeed achieved its purpose from its representative potential.

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