Introduction

The purpose of this chapter is to provide an overview of the viewpoints towards disability that are adopted, or might be adopted, in the field of adapted physical education (APE). However, before we explain these viewpoints, first we must address why it is important for people involved in APE to be able to explain and understand disability. One reason is because there is now an increasing variety of ways to conceptualize disability. Thus, these various viewpoints will have implications for disabled children, educators and facilitators, able-bodied classmates of disabled children, as well as society at large. For instance, how disability is viewed will impact how physical education (PE) teachers adapt, implement, and evaluate physical education activities.

Different viewpoints will also influence what is targeted in the pursuit of psychosocial development of disabled children; what is prioritized and what is left out of policy and research; how inclusion and exclusion are understood to influence the educational experiences of children; the importance of equality and equity; the educational experiences of children with disabilities and able-bodied classmates (without disabilities) of children with disabilities in PE; societal attitudes towards disability and impairment; the type and quality of instructions that educators give children; the quality of the training that educators receive; how physical activity contexts can influence and what is perceived as competence and confidence; legislation and policy and programming (Haegele & Hodge, 2016; Winnick & Portetta, 2016).

In this chapter, first we outline four models of disability: the medical model, the United Kingdom (UK) social model, the social relational model (SRM), and the human rights model of disability. We include the medical and social model, as these are historically dominant viewpoints towards disability in fields such as APE. As Aggerholm and Martiny (2017) write, adapted physical activity “is a cross-disciplinary field of study and practice, where interventions have historically been governed by what in disability research is referred to as the medical model, and to a lesser extent a social model of disability” (p. 1). Having problematized these two models, we then explain the SRM and human rights model of disability. These two viewpoints are selected
to highlight some emerging conceptualizations of disability that might be productively understood within the context of APE. After attending to these four models, we conclude with some progressive ways that APE scholars and practitioners can think about disability. These include a call for APE scholars to connect further with critical disability studies.

**Medical model**

The medical model, also known as the individual model of disability, has historically been the dominant way of understanding disability. In the medical model, disability is defined as a “medical problem that resides in the individual – a defect in, or a failure of, bodily system that is inherently abnormal and pathological” (Goodley, 2016, p. 7). Here, disability is understood as being “caused” by parts of the body that are lacking or do not work “properly” and it can, therefore, be “solved” by psychological or medical interventions performed by (often “able-bodied”) experts. A medical model has often, either knowingly or unknowingly, underpinned how disability is perceived, described, and depicted in various APE contexts. For example, Fitzgerald and Stride (2012) observed that, historically, a medicalized imperative has dominated research focusing on disability and physical education. They write “from this perspective, disability and ‘the disabled body’ have extensively been treated as an object to be tested, modified and re-tested” (Fitzgerald & Stride, 2012, p. 285). Goodley (2018) suggests the various ways a medical model can undergird practice in fields such as APE. For example, medicalized understandings of disability influence the language that abounds in APE contexts (e.g., children with special needs), how educators (without disabilities) identify the young people that they will work with, what forms of interventions will be used on disabled young people, and, how interventions are shaped by the language and practices of rehabilitation and medicine.

Although the medical model usefully promotes faith in medical intervention, and medical and technological advances will continue to greatly improve the lives of disabled people, this viewpoint has been heavily criticized. These critiques have largely emerged from disability rights activists and academics working within disability studies (Goodley, 2016). One problem with the medical viewpoint is that the highly influential field of medicine has conceptualized disability though a pathogenic lens (disability as pathology), rather than adopting a salutogentic position (disability as a continuum) (see Goodley, 2016). In doing so, the medical model has become the “ruling ideology” greatly responsible for the pathologization of disability. For example, Grenier (2007) highlights how this underlying authority can influence teachers, learners, and the knowledge they together produce in APE contexts:

The term ‘cognitive authority’ has been used to describe how entrenched attitudes influenced by the medical model of disability-as-illness depicts students with disabilities in the classroom whose challenges are defined in relation to prescribed methods of teaching and learning. The language used and the policies attached to these social conditions have the tendency to pathologize differences associated with disability. How this plays out in the schools varies depending on school philosophy, resources, and the general sentiment towards the treatment of students with disabilities.

(Grenier, 2007, p. 301)

Another problem with the medical model is that in reducing disability to biological components, this viewpoint shrinks the important influence of socio–historical–political–cultural–economic forces that shape the lives of disabled people. The medical model also paints
a very negative picture of disability (Smith & Bundon, 2018). For example, the model relies on bio-physical assumptions of “normality”, and, in doing so, creates a problematic normal/abnormal binary: the disabled (not normal) become “defective” and lose power and the able (normal) gain power. In addition, the “problem” of disability is located squarely within the body of the individual, problematically deeming disability a personal responsibility. Similarly, disability in the medical model is seen as a personal physical tragedy and a psychological trauma that should be overcome (rather than accommodated).

Medical model discourse can be seen in APE work in different ways (see Haegle & Hodge, 2016). For example, often APE authors do not explicitly state how they conceptualize disability, suggesting that this dominant viewpoint influences their work (e.g., Haegle & Porretta, 2015). As we discuss in this chapter, there are numerous viewpoints to adopt on disability, such as affirmative, social, social-relational, and human rights models. In addition, even if researchers themselves may not view disability from a medical lens, its dominance in contemporary culture often requires the use of the medical model in their research. This can be seen in the form of questionnaires that categorize on the basis of medical labels, or in participant recruitment strategies, such as in recent research by Haegle, Healy, and Zhu (2018) where parents were asked to identify “their children’s problem, illness or disability”. Also, entrenched medical model discourse can shape the knowledge of APE educators. As Grenier (2007) points out, the literature in inclusive education “clearly illustrates how the medical model populates teachers’ thoughts and mediates their preferences, as well as their dispositions, to students with disabilities” (p. 303). Further, research in adapted physical activity often compares some kind of behavior between one medically labelled disability group against their non-disabled peers (Jespersen & McNamee, 2008).

On top of these critiques, it is important to highlight how the field of psychology has also reduced disability to a problem that resides with the individual (Goodley, 2016). Influential perspectives (e.g., evolutionary and cognitive psychology), techniques (e.g., statistical analysis), and philosophies (e.g., post-positivism) that dominate the field of psychology have contributed towards the process of psychologization: the manufacturing of an ideal individual (i.e., the unitary-isolated-cognitively-able-rational-developed-innately-normed-consensual individual) against which we are expected to judge ourselves (Goodley, 2016). Therefore, APE research that frames experience based on cognitivist theories (e.g., Cervantes & Porretta, 2013) can be open to the accusation of reducing social barriers to the level of the individual, and has the potential to be viewed as apolitical, normalizing, and even oppressive (Goodley, 2016). For instance, this type of approach could imply that it is simply the responsibility of the individual to participate in physical activity, and, in so doing, disregard health inequalities that restrict activity (see Smith & Perrier, 2014). In light of such problems with the medical model, and the growing criticisms of it, alternative understandings have been developed. One of those viewpoints can broadly be labelled the social model of disability.

UK social model

Derived from the British disability rights organization—Union of the Physically Impaired Against Segregation (UPIAS), the United Kingdom (UK) social model, often referred to simply as “the social model”, understands and explains disabled people as socially oppressed. From this viewpoint, disability is not caused by biological impairment but by the social barriers (structural and attitudinal) that people with impairments (e.g., physical, sensory, cognitive, emotional) encounter daily in society (Owens, 2015). Importantly, in the social model, the concepts of impairment and disability are separated: impairment does not equate to
Impairment remains a biological phenomenon but disability becomes a wholly social phenomenon; in other words, people with impairments are (can be) disabled by society. Thus, the “solution” to disability does not lie in medical or psychological “cures” (as in the medical model) but lies in the eradication of disabling structural, political, social, economic, cultural, and psychological barriers (Goodley, 2016). As Goodley writes, “the social model approach is classic counter-hegemony: an alternative idea to the medical/individual tragedy that serves the aims of paramedical professions such as rehabilitation, medicine, psychology, special educational needs and social work” (Goodley, 2016, p. 11).

The UK social model is a barriers approach, underpinned by Marxism, rooted in the scholarship of British disabled intellectuals and UPIAS activists in the 1970s, 1980s and 1990s, such as Colin Barnes, Paul Hunt, Mike Oliver, and Vic Finkelstein. However, as Owens (2015) highlights, there are other similar but different social models that scholars and practitioners should be aware of. For example, the North American social model (also known as the minority model) similarly views disability as failure of social environments. However, this approach promotes a political response from an individual level (e.g., identity politics) rather than at a structural level, like the materialist focus on oppression in the UK social model. Likewise, the Nordic social relative model (also known as the Nordic relational model) rejects the medical dichotomy between illness and health, but views disability as a relative, situational, contextual, person–environment mismatch. Disability and impairment, from a Nordic social relative perspective, are explained as interacting with each other along a continuum. Despite these differences, as we discuss in the next paragraph, the social models viewpoint has been useful in a variety of ways.

The social model has, in many instances, been used to successfully challenge discrimination and marginalization, link civil rights and political activism, and enable disabled people to claim their rightful place in society. It has been a powerful tool for producing social and political change, for challenging the material problems experienced by many disabled people, and for driving emancipatory types of research, such as participatory action research. It has also been influential in producing anti-discrimination legislation in the form of various disability discrimination Acts around the world, including in the UK, France, and North America. Although certainly not perfect or always followed, these Acts mean that disabled people in numerous countries should now legally have equal access to education, sports arenas, employment, and so on. In addition, when disabled people encounter the social model, the effect can be revelatory and liberational. Rather than seeing themselves as the “problem” and the “solution” traced to their own individual bodies, disabled people have been empowered by the social model to recognize that society is often the problem and that the removal of social barriers to their inclusion and participation in social life is what is needed (Smith & Bundon, 2018).

In the context of APE, the social model has been drawn upon to explain and understand disability (see Haegele & Hodge, 2016). As Jespersen and McNamee (2008) explain, in adapted physical activity research, there has been a significant trend away from using the medical/individual tradition to understand disability towards connecting with the social model. For example, Grenier, Collins, Wright, and Kearns (2014) used the social model to frame their research. They were interested in how able-bodied young people’s perceptions of disability and APE would reflect and advance the social model. For instance, their study illuminated how young people’s perceptions of disability shifted from a medical to social model understanding after being introduced to disability sport. Their findings show how PE and school settings offer a useful space to challenge (medical lens) myths around disability. Bredahl (2013) explains that the social model has been predominantly used in APE research.
to understand teachers, administrators, or able-bodied peers’ experiences of participation in APE. For instance, a social model viewpoint is often used to emphasize the importance of addressing societal barriers in order to enhance participation in adapted physical activity.

While, under the umbrella of the social model, important achievements have been made, this model of disability has also been subject to numerous criticisms. Largely emanating from disability studies, critical disability studies, and the sociology of the body (see Owens, 2015; Thomas, 2012, 2014), these include the following. First, the social model has been accused of ignoring embodied experience at the expense of a focus on oppressive barriers. A materialist/Marxist worldview is useful for making political gains but less so for explaining varied embodied identities and a variety of lived disability experiences (e.g., illness, pain, fluctuating impairments). Second, the social model has created an unhelpful dualism between impairment and disability. The focus on disability has resulted in the impaired body being treated as simply biological; in doing so, this “gifts” the body to medical interpretation (Owens, 2015). Third, the social model does not explain disability adequately. For example, defining disability as oppression is simplistic (e.g., the social model makes no attempt to conceptualize the many components of disability). This lack of explanation positions the social model as a straw man argument or as a heuristic, rather than a comprehensive conceptual model. Fourth, oppression is poorly understood in the social model. For example, it says little about the origins of oppressive attitudes. Finally, it is argued that a world free of all physical barriers is idealistic. For instance, prominent disability theorists such as Carol Thomas and Thomas Shakespeare have argued that sometimes restrictions are indeed “caused” by impairment (see Thomas, 2014).

In light of such criticisms, for some (e.g., Shakespeare & Watson, 2001) the social model is an outdated ideology. The critiques, and subsequent conceptual moves to go beyond the social model, are particularly important when considered within the context of APE. This is because, when a disability model is explicitly utilized in APE research, it is often a social model of disability. Accompanying this use is, with rare exceptions, a silence surrounding the problems of a social model. For example, in fields such as the sociology of sport and sport psychology, there have been calls for both a social model understanding of disability and a focus on disabled bodies (see Smith & Perrier, 2014; Smith, Perrier, & Martin, 2016). In addition, although the social model and the medical model are conflicting viewpoints, they have similar limitations when explaining and understanding disability. For example, both models view disability as a problem: either a problem with the body or a problem with society. (However, scholars can also connect with the affirmation model of disability [Cameron, 2014; Swain & French, 2000] that celebrates the positive aspects of the disability community and explains disability as a proud identity.) In addition, both models ignore important experiences of disability (e.g., biological, psychological or social experiences). Thus, it is vital that researchers engage with the limitations of the social and medical models, but also connect with other models that address the concerns raised above. We now turn to two such models.

The social relational model (SRM)

APE scholars and practitioners can also connect with the SRM of disability (Thomas, 1999, 2004a, 2004b, 2007, 2012, 2014): a conceptually progressive understanding of disability that can be employed as an explanatory and analytical device. As described by Thomas (2007), the SRM builds on problems with the social model as well as on the discontent with the individualist tradition (e.g., medical model) that considers the individual mind and bounded/
autonomous self as the fundamental atom of human life (e.g., psychologization) (see Smith & Perrier, 2014). While the social and medical models conceptualize disability, disablism, and impairments as originating in the individual, in the SRM these are reconstituted as manifestations of social relationships (Thomas, 2007).

As Thomas (2007) argues, the study of disability should engage both with social structure (order) and social agency (action), and should therefore accommodate an analyses of social relations and social forces that construct, produce, institutionalize, enact and perform disability and disablism. The lived experience of both disablism and impairment should have its place, as should theorizations of impairment, per se.

(pp. 181–182)

In other words, what differentiates the SRM and makes it attractive, as we describe in the following paragraphs, is an expansion of how we understand disablism and impairment.

The SRM uniquely encompasses and extends our understating of disablism. Thomas (2014) promotes a focus on understanding of disablism as the term “disability” has acquired a confusing mix of meanings within disability studies and in society. Disablism, as defined by (Thomas, 2012) refers to:

The social imposition of avoidable restrictions on the life activities, aspirations and psycho-emotional well-being of people categorized as ‘impaired’ by those deemed ‘normal’. Disablism is social–relational in character and constitutes a form of social oppression in contemporary society – alongside sexism, racism, ageism, and homophobia. As well as enacted in person-to-person interactions, disablism may itself in institutionalized and other socio-structural forms [sic].

(Thomas, 2012, p. 211)

In other words, emerging not from an individual’s mind, but from oppressive relationships with structures and human beings, in the SRM different people at different times and places can experience different forms of social oppression; namely (a) psycho-emotional disablism, (b) structural disablism, and (c) internalized oppression (see Reeve, 2014). Psycho-emotional disablism can be separated out as emerging from two sources. Indirect psycho-emotional disablism is associated with the experience of structural disablism (e.g., exclusion from opportunities, services, and activities) and recognizes the psycho–emotional consequences of such experiences. For example, feelings of dislocation, humiliation or disrespect resulting from various levels of exclusion, such as inaccessible trains or being made to use the back entrance to access some buildings (Reeve, 2014).

The second source, direct psycho-emotional disablism, recognizes the consequences of discriminatory—often unpredictable—negative social interactions that disabled people can have with others. The looks, words, and actions of others (e.g., family, friends, strangers, professionals, other disabled people) can become pathologizing “acts of invalidation”. For example, being stared at or talked over, experiencing patronizing comments (“does she take sugar?”) or assumed tragedy (“what happened to you?”), and overhearing thoughtless words (“I’d rather be dead than in a wheelchair”) can contribute considerable emotional distress. Importantly, as Reeve (2014) highlights, there is also a concerning link between hate crime (e.g., 25% of people with disabilities report being victimized) and direct psycho-emotional disablism.
Internalized oppression, as described by Reeve (2014), emerges as a result of a relationship that disabled people can have with themselves as result of such hostility. Operating at a psychic level—often unconsciously—and common among subordinated groups, internalized oppression is a powerful example of disablism because it has direct influence on what disabled can become. Disabled people can devalue disability, lower self-worth and intrinsic value as a consequence of living in a culture that relentlessly views disability as negative. For example, internalizing ablest norms can be seen in behaviors such as disabled people positioning themselves in hierarchies relative to other disabled people (dispersal), hiding impairment to avoid negative reactions of others (emulation), or overachieving in order to prove they are better than “normal” (supercrip stereotype).

As exemplified in the work of Smith and Caddick (2015) and Richardson, Smith, and Papathomas (2017), the effects of psycho–emotional disablism, structural disablism, and internalized oppression can be profound. Self-esteem, confidence, feelings of worth and ontological security can be damaged as a result of negative social interactions, attitudes, and discourse—whether intended or unintended—in a PE lesson, for example. In such social interactions, a disabled person’s psycho–emotional well-being is not simply undermined. As a result of such undermining, they may avoid future behaviors such as taking part in PE. Hence, psycho–emotional disablism can damage well-being as well as place limits on what one can do and what one can become. Thus, the psycho–emotional register is progressive because it seeks to consider what “disabled people can be” rather than simply what “disabled people can do” (Goodley, 2016; Smith & Bundon, 2018; Smith & Perrier, 2014).

In addition to disablism, the SRM also usefully extends our understating of impairment. Thomas (2014) finds the binary separation of impairment and disability in disability studies unhelpful. Nonetheless, she promotes the analytical separation as a useful explanatory device. She argues that impairment and disablism are thoroughly intermeshed within the social conditions that bring them into being and, therefore, the conceptual focus should be on the relationship between them. In her critique of the materialist social modelist’s reluctance to “deal with” impairment, she highlights that there is a “reality” to impaired bodies and that this—material—experience within a social world requires attention; not all restrictions can be explained by wholly social barriers (e.g., physical pain). In other words, the biological entity can be held directly responsible for restricting some activities a person can do and, at times, damage psycho–emotional well-being. And that impairment, like disability, is also a socially constructed, culturally specific, linguistically shaped category (see Thomas, 2014).

To help in this regard Thomas (2012) introduces the concept of impairment effects into the SRM, defined as:

The direct and unavoidable impacts that ‘impairments’ (physical, sensory, intellectual, emotional) have on individuals’ embodied functioning in the social world. Impairments and impairment effects are always bio-social and culturally constructed in character, and may occur at any stage in the life course

(Thomas, 2012, p. 211)

The concept of “impairment effects” has been highly influential in British disability studies for several reasons (Goodley, 2016). First, it can allow scholars to acknowledge that impairments can have a direct and immediate impact on daily life without undermining the importance of prioritizing the impact of disablism (Thomas, 2014). This is because Carol Thomas argues for a more dialectic, non-reductionist (neither biologically nor culturally) materialist ontology of the body as opposed to, for example, Thomas Shakespeare’s biological
realities of the body (Goodley, 2016). Second, by centralizing impairment, the SRM can allow scholars to distinguish between restrictions in society due to the effects of impairment (impairment effects) and socially imposed restrictions (disablism) (Townsend, Cushion, & Smith, 2017). For example, when impairment effects are just corporeal, disablism is absent (i.e., social oppression is not engendered because it is the biological “realness” of having an impaired body that simply affects activity and well-being) (see Smith & Perrier, 2014). Third, it can allow scholars to view the body as biological, experienced, socially constructed, culturally fashioned, and agentic, thereby viewing impaired bodies as simultaneously biological, lived, social, and cultural (Smith & Perrier, 2014). Finally, connecting with impairment effects can allow scholars to understand that the biological reality of impairment can harm psycho-emotional well-being, and, at the same time, impairments can become a site for social oppression. For example, the effects of impairment can spread beyond restrictions caused just by biology to the socially engendered undermining of participation in activities and well-being (Smith & Bundon, 2018).

Although few APE scholars have explicitly connected with the SRM, combined recent research from the fields of disability sport, education, and psychology (Martin, 2013; Reindal, 2008; Simpson, McMillan, & Reeve, 2013; Smith & Perrier, 2014; Townsend et al., 2017) provide several reasons why explaining disability as a social relation is attractive. For example, connecting with the SRM can allow APE researchers to analyse and understand disability in APE at individual, social, cultural, and political levels; foreground disability as an experience of socialized impairment; understand that the experience of social oppression, inequality and cultural stereotypes of disability can be synonymous with the personal experience of physical impairment; show how stigmatizing attitudes contribute to the experience of physical, cognitive, or emotional restriction; draw upon a theoretical framework that accounts for individual differences as well as the experience of oppression in educational settings; understand how physical, social, and environmental barriers to APE are inextricably linked; understand the various social mechanisms that constitute oppression, othering, disablement, and, indeed, *enablement* in APE settings; critically attend to the influence of dominant discourses and practices in APE; expand how disability is positioned, understood, and translated in the formation and expression of APE knowledge, disablism, and impairment; think differently about disability; consider conventions, assumptions, and aspirations of research, theory, and activism; and, analyse disability in micro-contexts.

Let us pause here to give an example of how the SRM can be used to view behavior in an APE context. Imagine that a young person living with a condition labelled osteogenesis imperfecta (brittle bones disease) willingly attends PE class and mentions to her able-bodied PE teacher that she is in physical pain from breaking another bone in last week’s class—her second break this year. Her teacher instructs her that she cannot participate in this week’s session. Certainly, in this scenario, the biological reality of the body (e.g., pain from impairment) plays a role in preventing this particular physical activity. However, because the teacher imposes upon the young person what she can or cannot do, this social interaction becomes a potential site for oppression, and can damage her psycho-emotional well-being at a number of levels. For example, the young person is potentially reminded that her biological impairment can, at times, prevent social participation (impairment effect). Also, if the teacher is drawing on a set of misinformed cultural assumptions about what people with osteogenesis imperfecta can and cannot do, then here occurs an epistemic invalidation (i.e., direct psycho-emotional disablism). In addition, if the school steps in to prevent further activity in PE based on insurance grounds, this can be a form of structural disablism. On top of this, indirect psycho-emotional disablism...
can occur if she receives unintended patronizing remarks from other children, teachers or parents, based on this experience. Furthermore, the social interaction has the potential for the young person to place self-imposed restrictions on what she can do and become in the future (internalized oppression). Thus, from a viewpoint of the SRM, restrictions can simultaneously occur at an individual, social, and environmental level.

The social relational model is clearly complex. For some, this complexity is a limitation and serves only to overcomplicate an already complicated understanding of disability (see Shakespeare & Watson, 2010). For others, connecting with the SRM produced a concerning analytical task because they struggled to identify where the boundaries of impairment effects and disablism began and ended (and, indeed, the boundaries between direct and indirect psycho-emotional disablism) (see Owens, 2015). However, because impairment, disability, and disablism are so complex, this is exactly what makes the SRM attractive to some scholars in physical activity research (see Martin, 2013; Smith, 2013; Smith & Bundon, 2018). Certainly, the SRM needs to be empirically studied much more because it holds various potential benefits. One underused application of the SRM is to utilize this viewpoint to understand the effects of positive social relationships, such as the experience of enabling discourse and structures on psycho-emotional well-being and subsequent “ways of becoming”. Evidently, more dialogue with the SRM within the fields similar to APE is needed. The same can be said for the next model that we now attend to.

**Human rights model of disability**

Unlike the social model and the social relational model, the human rights model of disability is underpinned by rights-based principles. For example, in some parts of the world, rights-based disability discrimination legislation has had a significant influence on the development of APE (Winnick & Porretta, 2016). The *Americans with Disabilities Act* (1990) litigates for physical education so young disabled people can develop skills necessary to participate in recreation and leisure activities in community settings. More recently, also in the United States (US), the *Every Student Succeeds Act* (2015) supports the right to high quality physical education for disabled children (Winnick & Porretta, 2016). However, most countries have no such protection of their citizens with disability. As a result, pressure grew to develop an international convention that would be legally binding on nations to improve and document the position of disabled people in society. To recognize that disabled people have a right to access services from all areas of citizenship, such as PE opportunities, the United Nations’ *Convention on the Rights of Persons with Disabilities* (UNCRPD, United Nations, 2006) was introduced.

In contrast to approaches like that of the World Health Organization (2001) *International Classification of Functioning, Disability, and Health* (also known as the ICF), which focuses on the health condition of disabled people, the UNCRPD is founded on social approaches that recognize disability as the outcome of social processes. There are eight guiding principles that underlie the Convention and each one of its specific Articles. Together, the principles capture: (a) the human rights viewpoint towards disability; (b) what actions should be taken to undo any damage done to disabled people; and (c) what is needed to ensure that activities such as PE is a basic human right that any person can claim. The principles are: (1) respect for inherent dignity, individual autonomy, including the freedom to make one’s own choices, and independence of persons; (2) non-discrimination; (3) full and effective participation and inclusion in society; (4) respect for difference and acceptance of disabled people as
part of human diversity and humanity; (5) equality of opportunity; (6) accessibility; (7) equality between men and women; and (8) respect for the evolving capacities of disabled children and the right of disabled children to preserve their identities (United Nations, 2006). Grounded on these principles, the UNCRPD has several Articles that pertain to APE. For instance, Article 30 of the Convention recognizes physical activity and sport as important parts of any person’s citizenship. Article 24 of the Convention recognizes the right to education, including the rights of persons with disability to develop their physical abilities.

APE scholars who wish to adopt a human rights viewpoint can draw upon the UNESCO (2015) revised International Charter of Physical Education and Sport. This charter is a rights-based reference that understands “disability” in line with the UNCRPD and has several provisions addressing APE, such as stressing that resources for physical education must be allocated without discrimination on disability; adapted, safe opportunities to participate in physical education must be provided for persons with disabilities; safe spaces, facilities, and equipment for APE must be provided to meet the different need associated with disability. In addition, APE scholars can also draw on the recently adopted UNESCO (2017) Kazan Action Plan. This document connects physical education policy development with the United Nations 2030 Agenda for Sustainable Development (United Nations, 2015) and makes provision for disability. For example, this plan advocates that a minimum of 15% of urban areas should be allocated for integrating opportunities, such as sport and physical education, and should be designed to consider the needs of disabled people.

A recent special edition of the Journal of Sport for Development, titled “Disability Sport: Changing lives, changing perceptions”, provides examples of how APE scholars can use a human rights viewpoint to explore issues such as social change and pedagogy (see Britain & Wolff, 2015). For example, Devine et al. (2017) used a human rights model to assess the outcomes of a sport for development program. Their research showed how organizations are becoming more socially aware since the introduction of the UNCRPD, citing improved attitudes towards disability and improvements in the quality of life and economic empowerment for disabled people. In another example, Beacom and Golder (2015) adopt a UNCRPD perspective of disability to make a case for a critical pedagogy to help develop APE practitioners. They drew on a human rights model to argue that educators should be nurtured to challenge: established patterns of thinking about disability; established ways of working in APE settings; and, the systemic inequities increasingly characteristic of competitive disability sport in local and global settings (Beacom & Golder, 2015).

Additional future directions

So far, in this chapter, we have used a models approach to suggest some of the ways in which researchers in APE might conceptualize disability. However, the four models we have suggested are not the only ways to explain and understand disability. Scholars could also draw on the revised World Health Organization (2001) ICF while remaining mindful of the numerous critiques of it (see Reindal, 2008). For instance, the ICF is underpinned by a biopsychosocial model of disability that can imply an understanding of disability as a phenomenon of disadvantage. This is because restrictions of activity in the ICF are viewed in relation to activities that can be considered statistically “normal” or, in other words, can be positively desirable abilities in cultural context (Reindal, 2008). Narrative inquiry can also be a useful lens to make sense of disability in APE research. For example, narratives can illuminate young disabled people’s self-identities and socio-cultural contexts (e.g., Svendby &
Dowling, 2013); provide insight into the multiple realities of inclusion and/or exclusion, disability and PE (e.g., Svendby, 2016); and, contribute understandings beyond medically defined notions of disability by capturing complex lived experiences (e.g., Fitzgerald & Stride, 2012). Phenomenological scholars can capture individuals’ experiences as well as general structures of experience (Agerholm & Moltke Martiny, 2017; Bredahl, 2013). For example, Bredahl (2013) used a phenomenological lens to illuminate critical issues in APE (e.g., positive and negative experiences of PE for young disabled people).

A relatively new and exciting way to think about disability comes from the powerful emergence of what has come be called critical disability studies (CDS) (see Goodley, 2013; Shildrick, 2012). CDS can be described as a paradigmatic shift that builds on the foundational perspectives of disability studies (e.g., the social model of disability) while integrating new transformative agendas associated with the recent diversification of critical social theory (e.g., postcolonial, queer, and feminist theories) (Meekosha & Shuttleworth, 2009). The introduction of the word “critical” denotes a sense of self-appraisal: reassessing where we have come from, where we are now, and where we might be going (see Smith & Perrier, 2014). Thus, by connecting disability studies to intersections of class, gender, sexuality, race, and ethnicity, CDS has become a lens that goes beyond understanding disability to understanding society in general. As Goodley (2016) writes, “while critical disability studies might start with disability it never ends with disability” (p. 19). Thus, CDS is a space from which to think through a host of political, theoretical, and practical issues that are relevant to all. Shildrick (2012), for example, describes CDS as the academic site to watch because it is a space that can ask questions of embodiment, identity, and agency, as they affect all living things. Therefore, thinking about disability through a lens of CDS can help stimulate the field of APE, as it calls upon scholars to be open to using an eclectic range of theories and new lines of critical enquiry.

But what exactly are critical disability studies? A useful way to think of CDS is as the result of the emergence of many interrelated perspectives and developments in disability research over the past 20 years. Reflecting on recent writings (Goodley, 2013, 2016; Goodley, Liddiard, & Runswick-Cole, 2017; Meekosha & Shuttleworth, 2009; Shildrick, 2012; Smith & Bundon, 2018), these developments include the influence of disciplines previously on the outskirts of disability studies entering the field (e.g., affect studies); the incorporation of sophisticated social theories to make sense of complex social phenomenon (e.g., austerity, technology, inequality, globalisation, capitalism); a move to view disability as possibility and affirmative (i.e., “cripping” disability); an examination of resistance and agency; a move away from the preoccupation with binary explanations (e.g., disability/impairment and individual/society); a desire for more complex conceptual understandings of disability oppression (e.g., the social relational model); a move to challenge disablism (i.e., the social, political, cultural, and psycho-emotional exclusion of people with impairments) and ableism (i.e., the contemporary “normative” ideals on which the able, healthy, autonomous, productive citizen is based); a desire to theorize the material realities of disability (e.g., biological impairment); and, the merging of Marxist accounts with those from feminism, queer, post-colonial, critical men’s health, discourse or narrative studies.

Connecting with CDS also involves respecting the building blocks of disability studies (e.g., the social model of disability); considering the impact of global, national, and local economic contexts on the lives of disabled people; adopting a position of cultural relativism; remaining attuned to the relational qualities of disability (e.g., impairment in relative cultural context); understanding that any analysis of disability should not preclude consideration of other forms of political activism; promoting praxis (i.e., the intertwining of activism and
theory); conceptualizing the impaired body as simultaneously cultural, social, biological, fluid, lived, and could be lived; challenging the dogmatic tendencies of some theories and theorists through reference to an eclectic mix of theories; producing new ways that can inform activism and are informed by activism for the purposes of undoing some of the historic damage done to disabled people; throwing the spotlight on the community as the place to address issues of social change and well-being (Goodley, 2016; Meekosha & Shuttleworth, 2009; Smith & Bundon, 2018). Another way to understand what CDS are is to consider what CDS are not. As described by Goodley (2016), connecting with CDS is not a futile exercise that simply adds the word “critical” to disability studies to suggest that all previous examples of disability studies have not been critical; just another approach to sit alongside the traditional individual and social models of disability; a preoccupation with culture, power and structure; a simple study of disability and ability; an academic exercise without political commitment; or a movement away from an emancipatory focus around disability.

One way to frame CDS is by considering some emerging perspectives and analytical themes. Goodley (2016) highlights four emerging perspectives of activism and scholarship. Crip studies scholarship, for example, adopts a subversive position, rejects the view of disability as deficiency, and replaces it as a place of becoming, an affirmative account of being, or a celebratory moment of body politics. Critical studies of ableism (see Campbell, 2008) turns the gaze back to non-disabled people and shines a light on an underpinning prejudice resulting from a societal bias in favor of those who possess certain abilities over those who are believed not to. Global South disability studies remind us that disabled people in the Global South are often excluded from Global North discourses and discussions of disability and that, for example, localized knowledge (e.g., useful indigenous knowledge that can address disablism) are often ignored in favor of interventions devised in the Global North. Dis/ability studies (see Goodley & Runswick-Cole, 2014) captures the ways in which the politics of disability simultaneously disrupts (dis) and desires the norm (ability). This ambiguity recognizes the crip potential of disability to challenge disablism while also acknowledging the inevitable presence of ability and ableism.

Goodley (2016) also suggests three analytical themes that might shape the future of theory and research. First, engagement with CDS allows us to ask questions about how we might understand the human. For example, as we enter an increasingly technological and postmodern landscape, certain (disability) experiences can shift from undesired towards having a “futuristic desire”. Second, CDS questions the idea that bodies are biological. For instance, in what ways and when do disabled bodies rearticulate as “bodies that matter” (e.g., developing new positive identities after acquired impairment). Third, CDS allows us to question the differential workings of biopower (i.e., the co-construction of disability and ability, disablism and ableism, and illness and health through a host of biopolitical discourses, techniques, professions, and institutions).

Although holding many benefits, such as seeking to theorize in diverse ways and challenge marginalization in the name of disablism, viewing disability not necessarily a tragedy but as affirmative, and asking what bodies can do rather than what a body is, few APE researchers have connected explicitly with this way of thinking. However, the contributing authors for a recent special edition of Adapted Physical Activity Quarterly focused on themes of interdisciplinary, and provide some examples of how CDS can be applied to APE work (see Goodwin & Causgrove Dunn, 2018). Peer’s (2018) work, for example, connects with CDS to argue for the value of axiological reflection within fields such as APE. She shows how “interdisciplinary conversations” with fields such as queer studies can illuminate axiological assumptions (e.g., underlying often unquestioned values) in fields like APE that undermine
transdisciplinary research (researching involving stakeholders from outside the academy). For example, the axiological assumption that disability is inherently something bad (an assumption resulting from APE’s post positivist parent disciplines such as exercise physiology) rather than affirmative (influenced by connecting disability with queer studies) can influence whether strategies to fund research and adapted physical activity programs involve pitying, charitable giving, and inspirational overcoming rather than opportunity, rights, inclusion, and social justice.

Another recent example published in an APE outlet that connects with CDS can be found in Goodley (2018). He argues that working across disciplinary boundaries can help fields such as APE embrace the complex and often contradictory ways that disability labels (categories) work. He draws on three perspectives—the biopsychological, the biopolitical, and what he terms an in-between-all politics—to theorize about labeling, disability, and the human condition. For example, he draws on feminist and postcolonial theory to call for the usefulness of frictional politics (to simultaneously desire and reject labels). This “in-between-all” space can allow APE educators, researchers, and practitioners to move from questions about disability to questions about humanity; for instance—“in what ways might we learn again about our common humanity through the politics of disability?”

Furthermore, the work of Connolly and Harvey (2018) on preparing future practitioners/teachers in APE connects to CDS by advocating for an “eclectic and interdisciplinary disposition to theories of teaching and learning and adapted physical activity program delivery” (p. 295). These scholars demonstrate how blending knowledge from critical pedagogy (e.g., phenomenology and disability activist-oriented scholarship) and adapted physical activity (e.g., social and natural sciences) can help nurture the pedagogic sensibilities of APE student educators who will work with complex profile individuals in service-learning contexts. For example, Connolly and Harvey highlight that educators in training report experiencing a profound dissonance between their perceived competence and the demands of the placement context. They go on to suggest that integrating knowledge through interdisciplinary work (e.g., in course design, assessment, and evaluation) and connecting with CDS can help address this dissonance. Work by Szostak (2016) and Szostak (2018) also demonstrates the ways that connecting with CDS can add value to APE. They highlight how diverse thinking through interdisciplinary work can enhance research collaborations in a variety of ways, and reduce the perceived need for scholars to adhere to their disciplines particular ontologies, epistemologies, or theories. For example, disciplines can collaborate conceptually (e.g., conceptual resonances or complementarities), critically (tackle a problem or an analysis that involves multiple perspectives on a phenomenon), or instrumentally (develop strategic alliances based on shared goals) (Szostak, 2018).

It might also be said that other APE scholarship connects with CDS themes even though they do not mention critical disability studies. For example, Haycock and Smith (2011) investigate ableism, inclusion, and exclusion in APE. They suggest that including disabled children in mainstream education reduced, rather than enhanced, opportunities offered by the special school sector, due to an emphasis given competitive team sports that retain a strong emphasis on performance, excellence and skills. Sparkes, Martos, and Maher’s (2017) work, motivated by a desire to develop a socially just world, drew on various forms of critical pedagogy. Their critical approach challenged how knowledge is constructed and used in APE by, for example, suggesting ways that physical education teacher education (PETE) programmes can be developed to help practitioners to become more inclusive.
Haegele, Yessick, and Zhu (2018) connected with CDS when they explored the intersections between disability and gender among females with visual impairments in APE.

CDS are clearly and necessarily eclectic, and this eclecticism could be considered a limitation. But what brings CDS scholars together, say Meekosha and Shuttleworth (2009), is an agreement that addressing the continuing marginalization, undervaluing, and discrimination of disabled people requires diverse theoretical lenses as these cannot be addressed simply through liberal or neo-liberal policy and legislation. Therefore, we contend that connecting with CDS can contribute to important empirical, conceptual, and theoretical developments that will help APE scholars explain and understand disability.

Summary of key points

- There are an increasing variety of viewpoints towards disability, with no consensus on a way forward.
- Using conceptual models to explain and understand disability has been a popular approach within disability studies.
- A medical–individual model viewpoint remains the dominant way that disability is understood in many parts of academia, as well as in society at large.
- The discipline of psychology has contributed towards the individualization of disability.
- The medical–individual tradition paints a negative picture of disability.
- The UK social model of disability emerged from disability activism as a direct riposte to the medical–individual tradition.
- There are various forms of social models, such as the North American social model, the Nordic relative model, and the affirmative model.
- The UK social model of disability has made a significant contribution to improving the lives of disabled people. However, it is a weak explanation of disability.
- There are many critiques of UK social model. However, these are rarely mentioned by APE scholars.
- The social relational model is a conceptually progressive way to view disability because it accounts for the limitations of the medical and social models and expands how we understand impairment and disablism. For these reasons, it is also a useful analytical device for researchers.
- Carol Thomas’s concept of impairment effects has been hugely popular in disability studies because it allows researchers to attend to impairment without reverting to the essentialist understandings of the medical model.
- Scholars should be aware of the various international rights conventions and charters that can be drawn upon to advocate for the development of APE.
- The human rights viewpoint towards disability is useful for tracking social change over time, particularly from an international perceptive.
- There are various ways, beyond a models approach, to view disability, such as by drawing on phenomenology and narrative enquiry.
- Critical disability studies (CDS) have become the emerging landscape to think about disability in this century.
- Critical disability studies may start with disability but never end with it. CDS have become an exciting viewpoint to ask questions about life itself.
Reflective questions

1. The medical model underpins the majority of APE research. However, this viewpoint is rarely explicitly mentioned in research papers. Why is this the case?
2. Why is it important for APE scholars to explicitly state their viewpoints toward disability?
3. Is the UK social model “a poor explanation of disability”? Discuss.
4. Why is the social relational model of disability a useful analytical device, and what might be some of the weaknesses of this model?
5. Is “critical disability studies a progressive way to view disability”? Discuss.

References


