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Models of disability: A brief overview

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Critical reflection on the importance of shaping disability-friendly – or disability-inclusive – congregations has enjoyed increasing attention in the field of practical theology in recent years. Moreover, the development of disability theology is a testament to the fact that practical theologians and the wider church community have taken serious notice of the realities and experiences of people with disabilities in our time. Nevertheless, even before the task of engaging in theological reflection from a disability perspective commences, it is necessary that theologians acquaint themselves with the various models of disability that shape people's perceptions and ideas about people with disabilities. Guided by the principles of the interpretive task of practical theological investigation and cognizant of the importance of models of disability in shaping perceptions regarding people with disabilities, this article seeks to provide a brief overview of nine of the most dominant models of disability that are prevalent in our time. We shall utilise the typological approach to theoretical analysis in order to outline the basic characteristics of the various models.

Introduction

Critical reflection on the importance of shaping disability-friendly – or disability-inclusive – congregations has enjoyed increasing attention in the field of practical theology in recent years (cf. Brock & Swinton 2012; Eiesland & Saliers 1998; Swinton 2000, 2001, 2011, 2012). Nevertheless, we would be mistaken to assume that practical theology has been alone in drawing attention to the needs and experiences of people with disabilities (hereafter PWDs). On the contrary, the nascent academic discipline commonly referred to as disability theology is very much a multidisciplinary affair, drawing on biblical studies, systematic theology, moral theology, church history and practical theology, as well as disciplines outside the field of theology, such as sociology, ethics, education, psychology and philosophy (Swinton 2011:275). Broadly defined, the term 'disability theology' denotes:

> [*The*] attempt by disabled and non-disabled Christians to understand and interpret the gospel of Jesus Christ, God, and humanity against the backdrop of the historical and contemporary experiences of people with disabilities. It has come to refer to a variety of perspectives and methods designed to give voice to the rich and diverse theological meanings of the human experience of disability. (Swinton 2011:274)

The development of disability theology is testimony to the fact that practical theologians and the wider church community have taken serious notice of the realities and experiences of PWDs in our time.

Even before the task of engaging in theological reflection from a disability perspective commences, it is necessary that theologians acquaint themselves with the various models of disability that shape people's perceptions and ideas about PWDs. Such a preliminary assessment of various models of disability is important, because, as Smart (2004:25–29) points out, such models serve a number of important purposes:

- Models of disability provide definitions of disability.
- Models of disability provide explanations of causal attribution and responsibility attributions.
- Models of disability are based on (perceived) needs.
- Models guide the formulation and implementation of policy.
- Models of disability are not value neutral.
- Models of disability determine which academic disciplines study and learn about PWDs.
- Models of disability shape the self-identity of PWDs.
- Models of disability can cause prejudice and discrimination.

Guided by the principles of the interpretive task of practical theological investigation and cognizant of the importance of models of disability in shaping perceptions regarding PWDs, this

Note: This article is based on research and writing, previously published by the author.

article seeks to provide a brief overview of nine of the most dominant models of disability that are prevalent in our time. Drawing inspiration from Niebuhr's *Christ and Culture* (1956) and Dulles' *Models of the Church* (1974), we shall utilise the typological approach to theoretical analysis in order to outline the basic characteristics of the models in question.

The moral and/or religious model: Disability as an act of God

The moral/religious model of disability is the oldest model of disability and is found in a number of religious traditions, including the Judeo-Christian tradition (Pardeck & Murphy 2012:xvii). According to one of the primary forms of moral and/or religious models of disability, disability should be regarded as a punishment from God for a particular sin or sins that may have been committed by the person with disability. Henderson and Bryan (2011) offer a thorough explanation of the moral and/or religious model of disability:

> [*S*]ome people, if not many, believe that some disabilities are the result of lack of adherence to social morality and religious proclamations that warn against engaging in certain behavior. To further explain this model, some beliefs are based upon the assumption that some disabilities are the result of punishment from an all-powerful entity. Furthermore, the belief is that the punishment is for an act or acts of transgression against prevailing moral and/or religious edicts. (p. 7)

McClure (2007:23) laments the devastating influence the thinking characteristic of the moral and/or religious model of disability has had on preaching, highlighting how some forms of Bible interpretation exclude PWDs by directly or indirectly equating '"blindness", "lameness", "deafness", "uncleanness" (chronic illness), mental illness (demonic possession), and other forms of disability . . . with human sin, evil, or spiritual ineptitude'.

Sometimes it is not only the individuals' sin that is regarded as a possible cause of their disability, but also any sin that may have been committed by their parents and/or ancestors (Henderson & Bryan 2011:7). Elaborating on the negative impact of this model on the individual with disability and his or her family, Rimmerman (2013:24) emphasises the potentially destructive consequences of such a view, in the sense that it may lead to entire families being excluded from social participation in their local communities.

Another prominent form of the moral and/or religious model of disability is the idea that disabilities are essentially a test of faith or even salvific in nature. Niemann (2005:106) offers a concise description of the conception of disability as a test of faith, whereby 'individuals and families are specially selected by God to receive a disability and are given the opportunity to redeem themselves through their endurance, resilience, and piety'. Black (1996:26) points out that some people conceive of passing the test of faith as receiving physical healing. If the person does not experience the physical healing of their disability, he or she is regarded as having a lack of faith in God.

Black (1996:27) discusses an additional form of the moral and/or religious model of disability, whereby the challenges associated with disability are viewed as a God-given opportunity for character development. Such an understanding regards the development and deepening of particular character traits (such as patience, courage and perseverance) as the primary focus of God's plan for PWDs. Consequently, PWDs may be regarded as 'blessed', as they have the opportunity to learn some important life lessons that able-bodied people do not necessarily have the opportunity to learn.

Sometimes the moral and/or religious model of disability perpetuates the myth of disability as mysticism or some kind of metaphysical blessing. According to the mysticism perspective of disability, the fact that one of the senses of a person is impaired inevitably heightens the functioning of other senses of that person, as well as granting him or her 'special abilities to perceive, reflect, transcend, be spiritual' (Olkin 1999:25–26). From this perspective, '[*I*]ndividuals are selected by God or a higher power to receive a disability not as a curse or punishment but to demonstrate a special purpose or calling' (Niemann 2005:106).

Although the moral and/or religious model of disability is no longer as prevalent as it was in in premodern times, the basic philosophy underlying the model is still frequently encountered in the way people reason when confronted with illness or disability (cf. Henderson & Bryan 2011:7; Rimmerman 2013:24). Moreover, there are certain cultures where the moral and/or religious model of disability is still the predominant view (Dunn 2015:10), especially 'societies dominated by religious or magical ways of thinking' (Karna 1999:13). In such societies, PWDs are often severely marginalised, even facing the prospect of abandonment or infanticide (Anderson 2013:11).

Niemann (2005:106) highlights the negative influence of the moral and/or religious model of disability on theological reflection: 'Whether congenital or acquired, many theologies have historically constructed disabilities to be a curse, one often associated with the attribution of shame onto an individual or family'. Most contemporary biblical scholars and theologians reject the moral and/or religious model of disability (cf. Creamer 2009; Yong 2007, 2011), although it is still found – in some form or other – in some theological circles (cf. Swartley 2012).

The medical model: Disability as a disease

From the mid-1800s onwards, the medical (or biomedical) model of disability began to gradually replace the moral and/or religious model in lieu of significant advances in the field of medical science. Olkin (1999) outlines the basic characteristics of the medical model of disability:

> Disability is seen as a medical problem that resides in the individual. It is a defect in or failure of a bodily system and as

> such is inherently abnormal and pathological. The goals of intervention are cure, amelioration of the physical condition to the greatest extent possible, and rehabilitation (i.e., the adjustment of the person with the disability to the condition and to the environment). Persons with disabilities are expected to avail themselves of the variety of services offered to them and to spend time in the role of patient or learner being helped by trained professionals. (p. 26)

The medical model of disability is sometimes also referred to as the 'personal tragedy' model (Thomas & Woods 2003:15), because it defines disability in a fundamentally negative way. Disability is regarded as objectively bad, as a pitiable condition, 'a personal tragedy for both the individual and her family, something to be prevented and, if possible, cured' (Carlson 2010:5). As Carlson points out, this negative conception of disability has contributed to some of the questionable medical treatments performed on PWDs, including, for example, involuntary sterilisation and euthanasia.

According to the medical model, PWDs deviate from what is normal. Terms such as 'invalid', 'cripple', 'spastic', 'handicapped' and 'retarded' are all derived from the medical model (Creamer 2009:22). This approach to disability reinforces the notion that PWDs are not comparable with their able-bodied counterparts. As Johnstone (2012:16) avers, 'The medical model of interpretation of disability projects a dualism which tends to categorise the able-bodied as somehow 'better' or superior to people with disabilities'.

Medical professionals who subscribe to the medical model tend to treat people as problems to be solved, often failing to take into account the various aspects related to the person's life as a whole (Thomas & Woods 2003:15). Kasser and Lytle (2005:11) highlight the medical model's exclusive focus on the limitation(s) associated with a person's disability, which essentially '[*disregards*] environments that might intensify or adversely affect a person's functional abilities'. Accordingly, the medical model tends to regard the person with disability as the one who needs to change or be fixed, not the conditions that might be contributing to the person's disability (Kasser & Lytle 2005:11).

The medical model of disability assigns tremendous power to the medical professionals who diagnose people using criteria such as the ones noted above, because the very criteria being used for diagnosis have been developed from the perspective of what is considered 'normal' in society (Thomas & Woods 2003:15). Nevertheless, because many PWDs will never experience a cure that eliminates their disability, it is often the case that medical professionals who adhere to the medical model will regard PWDs as failures and an embarrassment (Pfeiffer 2003:100).

In his seminal sociological study of illness and the role of the physician, Parsons (1951) insightfully described the basic characteristics of the 'sick role' people are expected to play in any social context where the medical model prevails:

> The first of these is the exemption of the sick person from the performance of certain of his normal social obligations. . . . Secondly, the sick person is, in a very specific sense, also exempted from a certain type of responsibility for his own state . . . The third aspect of the sick role is the partial character of its legitimation, hence the deprivation of a claim to full legitimacy . . . Finally, fourth, being sick is also defined, except for the mildest cases, as being 'in need of help'. (pp. 455–456)

For medical professionals who adhere to the medical model of disability, PWDs should play the 'sick role' properly if they desire to receive continued help and support. However, Llewellyn, Agu and Mercer (2008:256) highlight the shortcomings of the medical model's 'sick role' approach, especially in relation to the fact that many chronically ill or disabled people do not consider themselves as sick. Furthermore, the 'sick role' approach fails to take account of the vital distinction between impairment and sickness. As Llewellyn et al. (2008:256) note, 'Many disabled people are not sick, but have ongoing impairments that do not present as daily health problems'.

The social model: Disability as a socially constructed phenomenon

Inspired by the activism of the British disability movement in the 1960s and the 1970s, the social model of disability developed in reaction to the limitations of the medical model of disability (D'Alessio 2011:44). According to the social model (sometimes also referred to as the minority model), it is society 'which disables people with impairments, and therefore any meaningful solution must be directed at societal change rather than individual adjustment and rehabilitation' (Barnes, Mercer & Shakespeare 2010:163). One of the most important documents in the development of this approach is the Union of the Physically Impaired against Segregation's (UPIAS) manifesto document, *Fundamental Principles of Disability* (1976). Fundamental to the social model of disability is the notion that disability is ultimately a socially constructed phenomenon. UPIAS (1976) emphasises the importance of this social dimension in its definition of disability:

> [*D*]isability is a situation, caused by social conditions, which requires for its elimination, (a) that no one aspect such as incomes, mobility or institutions is treated in isolation, (b) that disabled people should, with the advice and help of others, assume control over their own lives, and (c) that professionals, experts and others who seek to help must be committed to promoting such control by disabled people. (p. 3)

Oliver (1981:28), a disabled activist and lecturer, who also coined the phrase 'social model of disability', stresses the need to focus on the social aspects of disability, especially how 'the physical and social environment impose limitations upon certain categories of people'.

UPIAS (1976) draws an important conceptual distinction between the terms 'impairment' and 'disability'. Impairment

is defined as 'lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body', while disability is defined as:

> the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. (UPIAS 1976:14)

From this point of view, disability is a socially constructed disadvantage, which is, in a very real sense, imposed on PWDs, constituting 'a particular form of social oppression' (UPIAS 1976). Schipper (2006) explains the critical importance of the distinction between impairment and disability in the development of the social model, especially in terms of its relevance to different cultures:

> These definitions provided a theoretical underpinning for the social model by making a clear distinction between social disability and physical impairment. While an impairment is universally constant (e.g. the inability to conceive children), the extent to which this impairment has social/political consequences shifts from culture to culture (i.e. the inability to conceive children may be more 'disabling' in ancient Near Eastern cultures than in industrialized Western ones). (p. 17)

UPIAS' approach has subsequently been slightly amended by those working in the disability community so that the term 'impairment' is utilised in preference to the term 'physical impairment', which could be construed as excluding sensory and intellectual disabilities (Barnes et al. 2010:163).

Social model theorists argue that the term 'people with disabilities' is directly linked to the philosophy underlying the medical model and therefore insist that the term 'disabled people' better reflects the societal oppression that people with impairments are faced with every day. As Purtell (2013:26) observes, '[D]isabled people are people who are "disabled" by the society they live in and by the impact of society's structures and attitudes'. Purtell illustrates the social model's argument about the utility of the term 'disabled people' by reference to people with learning difficulties: 'People with learning difficulties are 'disabled people' whose impairment is their learning difficulty: they are disabled by the social reactions to it' (2013:26). The social model is especially concerned with addressing the 'barriers to participation' experienced by PWDs as a result of various ableist social and environmental factors in society (O'Connell, Finnerty & Egan 2008:15).

The social model of disability has had a profound influence on how disability is understood in our time (Giddens 2006:282). The social model has played a crucial role in shaping social policy *vis-à-vis* PWDs, not only in national levels but also in international level. In the South African context, the social model is reflected in the *Integrated National Disability Strategy* (1997), as well as the Department of Labour's *Code of Good Practice: Key Aspects on the Employment of People with Disabilities* (2002).

Within the field of disability theology, the theological models of Block (2002) and Eiesland (1994) may be regarded as variants of the social model of disability (Creamer 2006). Block (2002:11) argues for a 'theology of access' and calls on the church to challenge oppressive social and ecclesial structures, ensuring 'that people with disabilities take their rightful place within the Christian community'. Block's (2002:122) reliance on the social model is evident when she emphasises the church's need to 'search our community with truth and face the serious reality that some of the people of God have been systematically denied access to the community'.

Eiesland (2002:10) is also in agreement with the central argument of the social model when she declares, 'Sadly, rather than offering empowerment, the church has more often supported societal structures and attitudes that have treated people with disabilities as objects of pity and paternalism'. Eiesland's (2002) emphasis on the serious need for social change is cogently articulated in her remarks about 'disabling theology':

> The problem is a disabling theology that functionally denies inclusion and justice for many of God's children. Much of church theology and practice – including the Bible itself – has often been dangerous for persons with disabilities, who encounter prejudice, hostility, and suspicion that cannot be dismissed simply as relics of an unenlightened past. Christians today continue to interpret and spin theologies in ways that reinforce negative stereotypes, support social and environmental segregation, and mask the lived realities of people with disabilities. (p. 10)

In order to develop a 'liberating theology of disability', Eiesland (2002:10–12) insists on the need to critically examine the Biblical foundation of disabling theology, and subsequently the production of 'a theology of disability, emerging from the lives and even the bodies of those with disabilities'.

Both Block's and Eiesland's approaches to the social model of disability have been criticised (cf. Adam 2014; Creamer 2009). Creamer (2009:88–89) questions the utility of Block's approach once social and ecclesial injustices against PWDs have been remedied, noting three points of concern. Firstly, while the notion of an Accessible God imbues PWDs with a sense of God's solidarity with them, it fails to offer 'clear direction in terms of action, devotion, or even imagination' (Creamer 2009:88). Secondly, Block's image of an Accessible God does not provide churches and able-bodied people with a holistic approach: 'This image demands justice and inclusion but proposes little else about God or about human life'. Thirdly, even in terms of its utility for developing an inclusive community, Block's approach 'offers little that would aid in the construction of an inclusive community' (Creamer 2009:89). As for Eiesland's notion of the Disabled God, Adam (2014) questions to what extent such a metaphor may offer a sense of eschatological hope for Christians with disabilities:

> [*T*]he eternal condition of the disabled God has yet to be narrated. Humans and God could share disabilities eternally, but that scenario does not relieve resurrected people of their disabilities. (pp. 185–186)

While a number of people in the disability community regard the insights of the social model as liberating, Giddens (2006:283) notes several points of critique that have been noted against the social approach. Firstly, some argue that the social model seemingly ignores the often painful realities of impairment. As Shakespeare and Watson (in Giddens 2006:283) remark, 'We are not just disabled people, we are also people with impairments, and to pretend otherwise is to ignore a major part of our biographies'. Secondly, while many people accept the fact that they have impairments, they prefer not to be referred to as 'disabled'. Giddens (2006:284) notes a recent survey of people claiming government benefits that found fewer than half the people opted to describe themselves as disabled. Lastly, medical sociologists are very sceptical of the model, as they reject the social model's distinction between impairment and disability as artificial. While acknowledging that the differentiation seems valid at the surface, such a simplistic division collapses once one asks the following question: 'where does impairment end and disability start?'

Social model theorists have responded to critique such as the above by pointing out that they neither deny the fact that some forms of illness may have disabling consequences nor do they deny the role of medical professionals in treating various illnesses. For these theorists, the problem is that medical professionals fail to distinguish between a person's illness and his or her disability.

The identity model: Disability as an identity

Closely related to the social model of disability – yet with a fundamental difference in emphasis – is the identity model (or affirmation model) of disability. This model shares the social model's understanding that the experience of disability is socially constructed, but differs to the extent that it 'claims disability as a positive identity' (Brewer et al. 2012:5). Brewer et al. (2012) offer the following illuminating definition, which also explains how the identity model departs from the social model's approach:

> Under the identity model, disability is a marker of membership in a minority identity, much like gender or race . . . Under an identity model, disability is primarily defined by a certain type of experience in the world – a social and political experience of the effects of a social system not designed with disabled people in mind . . . [*W*]hile the identity model owes much to the social model, it is less interested in the ways environments, policies, and institutions disable people, and more interested in forging a positive definition of disability identity based on experiences and circumstances that have created a recognizable minority group called 'people with disabilities'. (p. 5)

Swain and French (2000:577–578) discuss a number of ways in which the identity model of disability, which they term 'the affirmation model', shapes the identity of PWDs:

- An acknowledgement of the socially constructed dimension of disability, especially as articulated by the social model.
- Motivating PWDs to belong to a campaigning group, which aids in the development of a collective identity.
- The collective expression of 'frustration and anger'.
- A realisation that there is nothing wrong with PWDs embracing an identity as 'outsiders', but PWDs should have the right to be 'insiders' if they prefer.
- Group identity has inspired many PWDs to endeavour for revolutionary 'visions of change, often under the flags of "civil rights" and "equal opportunities"'.

The identity model has influenced many in the disability community, inspiring PWDs to adopt a positive self-image that celebrates 'disability pride' (Darling & Heckert 2010:207).

As with the social model, the identity model is not without its critics. One of the major points of critique against the approach is that it seems to compel individuals to identify with a specific group culture (Fraser 2003:26). A further point of critique is that the identity model negates the struggle for redistribution, failing to pay sufficient attention to the reality of economic inequality faced by PWDs (Fraser 2003:24).

The human rights model: Disability as a human rights issue

Another model that bears close affinity to the social model of disability is the human rights model of disability. Although some researchers treat the social model and the human rights model as virtually synonymous, Degener (2017) highlights a number of important differences between them. Firstly, while the social model helps people to understand the underlying social factors that shape our understanding of disability, the human rights model moves beyond explanation, offering a theoretical framework for disability policy that emphasises the human dignity of PWDs (Degener 2017:43). Secondly, the human rights model incorporates both first and second generation human rights, in the sense that 'it encompasses both sets of human rights, civil and political as well as economic, social and cultural rights' (Degener 2017:44). Thirdly, while the social model mostly fails to appreciate the reality of pain and suffering in the lives of some PWDs, the human rights model respects the fact that some PWDs are indeed confronted by such challenging life situations and argues that such factors should be taken into account in the development of relevant social justice theories (Degener 2017:47). Fourthly, while the social model does not pay adequate attention to the importance of identity politics, the human rights model 'offers room for minority and cultural identification' (Degener 2017:49). Fifthly, while the social model is mostly critical of public health policies that advocate the prevention of impairment, the human rights model recognises the fact that properly formulated prevention policy may be regarded as an instance of human rights protection for PWDs (Degener 2017:52). Lastly, while the social model can helpfully explain why so many PWDs are living in poverty, the human rights model offers constructive proposals for improving the life situation of PWDs (Degener 2017:54).

The cultural model: Disability as culture

The cultural model of disability developed in the North American context, where disability studies have been approached in an interdisciplinary manner by a number of scholars working in the social sciences and humanities (cf. Michalko 2002; Titchkosky 2007). Junior and Schipper (2013:23) outline the primary characteristics of the cultural model, specifically in terms of how it differs from the medical model and social model. While the medical model and the social model each focus on only one factor in their approach to disability, the cultural model focuses on a range of cultural factors. Such factors may include medical and social factors but are by no means limited to these factors. Accordingly, the cultural approach does not seek to define disability in any specific way but rather focuses on how different notions of disability and non-disability operate in the context of a specific culture.

The work of Snyder and Mitchell (2006) has played a critically important role in shaping the theoretical contours of the cultural approach to understand disability. Snyder and Mitchell (2006) argue that particular 'cultural locations of disability' have been created on behalf of PWDs, locations where PWDs 'find themselves deposited, often against their will'. Some of these 'cultural locations' include:

> nineteenth century charity systems; institutions for the feebleminded during the eugenics period; the international disability research industry; sheltered workshops for the 'multi-handicapped'; medically based and documentary film representations of disability; and current academic research trends on disability. (p. 3)

The primary problem with these manufactured locations is the modernist assumptions which underpin them, specifically the strategy 'to classify and pathologize human differences (known today as disabilities) and then manage them through various institutional locations' (Snyder & Mitchell 2006:4–5). Nevertheless, such artificial or manufactured locations of disability knowledge should be distinguished from 'more authenticating cultural modes of disability knowledge', which are necessary and important ways of understanding disability, for example, 'the disability rights movement, disability culture, the independent living movement, and other experientially based organizations of disabled people' (Snyder & Mitchell 2006:4).

The cultural model of disability is gaining increasing acceptance in the disability community, especially through its adoption by a number of deaf culture theorists (cf. Holcomb 2013; Lewis 2007).

The charity model: Disability as victimhood

According to the charity model, PWDs are victims of circumstance who should be pitied. As Duyan (2007:71) explains, 'The Charity Model sees people with disabilities as victims of their impairment. Their situation is tragic, and they are suffering'. Able-bodied people should therefore assist PWDs in whatever way possible, as 'they need special services, special institutions, etc., because they are different' (Duyan 2007:71). In contrast with the moral and/or religious model of disability, which has a largely negative view of PWDs, the charity model seeks to act to the benefit of PWDs, encouraging 'humane treatment of persons with disabilities' (Henderson & Bryan 2011:7–8).

Many people in the disability community regard the charity model in a very negative light. The model is often seen as depicting PWDs as helpless, depressed and dependent on other people for care and protection, contributing to the preservation of harmful stereotypes and misconceptions about PWDs (Seale 2006:10).

The economic model: Disability as a challenge to productivity

The economic model of disability approaches disability from the viewpoint of economic analysis, focusing on 'the various *disabling effects* of an impairment on a person's capabilities, and in particular on labour and employment capabilities' (Armstrong, Noble & Rosenbaum 2006:151, original emphasis). While the economic model insists on the importance of 'respect, accommodations, and civil rights to people with disabilities', such concerns are subservient to the economic model's estimation of a disabled person's ability to work and contribute to the economy (Smart 2004:37).

The economic model is often utilised by governments as a basic point of reference for formulating disability policy (Jordan 2008:193). In South Africa, the influence of the economic model may be seen in the definition of disability adopted by the Department of Labour's *Code of Good Practice: Key Aspects on the Employment of People with Disabilities* (2002):

> People are considered as persons with disabilities who satisfy all the criteria in the definition: (i) having a physical or mental impairment; (ii) which is long term or recurring; and (iii) which substantially limits their prospects of entry into or advancement in employment. (Paragraph 5.1)

The economic model of disability has been criticised for framing disability almost exclusively in terms of a cost–benefit analysis, neglecting to take other important factors into account (cf. Aylward, Cohen & Sawney 2013; Smart 2004). Such an economic focus may contribute to the dehumanisation of the person with disability as someone who is somehow 'missing parts' (Stone cited by Smart 2004:40).

The limits model: Disability as embodied experience

According to the limits model of disability – a distinctly theological model of disability developed by Creamer (2009) – disability is best understood with reference to the

notions of embodiment and 'limitness'. Firstly, with regard to understanding the concept of embodiment, Creamer (2009:57), along with embodiment theologians such as McFague (1993), argues that the reality of the human body should be taken seriously when engaging in theology. From this point of view, the reality of embodied experience must be regarded as an important source for engaging in theology (Creamer 2009:57). Creamer (2009:56) emphasises that such theological reflection focuses on 'all that is written on, of, or by the body, going far beyond sensory experiences to include science, politics, economics, media, and many other concerns of postmodern life'. Moreover, such an approach has particular significance for how the issue of disability is approached, especially when considered in the context of what Creamer (2009:96) calls 'limit-ness'.

According to the limits model, it is important that people accept the fact that all human beings experience some level of limitation in their everyday lives (Creamer 2009:109). Moreover, such limits are experienced to varying degrees during all the phases of our life (Creamer 2009:118). Rather than being something foreign to human experience, limits are as a matter of fact 'a common, indeed quite unsurprising, aspect of being human' (Creamer 2009:31). Indeed, Creamer (2009:96,116) prefers to utilise the neologism 'limit-ness' – as opposed to the terms 'limitation' or 'limitedness' – in order to emphasise that 'human limits need not (and perhaps ought not) be seen as negative or as something that is not or that cannot be done', but rather as 'an important part of being human'. Furthermore, as people experience 'various formations' of embodiment, 'disabled embodiment' is one of those formations of embodiment (Creamer 2009:32).

The limits model of disability has profound implications for how disability is understood. Firstly, it seeks to avoid categorisation such as 'disabled', 'able-bodied', 'abnormal body' or 'normal body', preferring to focus on 'a web of related experiences' that recognises – for example – that a person who is legally blind might have more in common with someone who wears glasses than someone who uses wheelchair (Creamer 2009:31).

Secondly, because the limits model emphasises that 'limits are an unsurprising aspect of being human' (Creamer 2009:93), it guards against overdetermining the situation of PWDs *vis-à-vis* the wider population (Mawson 2013:410). As Creamer (2009) points out:

> This model also highlights that limits go far beyond those labelled as part of the province of disability, and shows that some limits are viewed as more normal (I cannot fly) than others (I cannot run). (p. 96)

Lastly, while acknowledging the social model's key insight that disability is primarily social in nature, the limits model departs from the social model by allowing for the viewpoint that not 'all limits are necessarily "normal" or even "good"' (Creamer 2009:109). Mawson (2013:411) further explains this aspect of the limits model, noting how embodied experience puts things in different perspective by 'recognizing that some of us may wish to strive to overcome certain limits, that is, without suggesting that limitedness itself is simply something that should be overcome'.

Conclusion

This article has outlined nine models of disability that continue to impact the way in which people conceive of PWDs. While these are by no means the only models of disability that may be encountered in our time, they are the most dominant models of disability today. Any theologian who wishes to engage in theology from a disability perspective will do well by first engaging in some critical self-examination to determine the extent to which one or more of the above models of disability influence their thinking about PWDs. Once the theologian is clear about which model(s) of disability shapes his or her thinking, he or she may commence the creative process of constructing a disability theology that is Christ-centred, biblically rooted and relevant to the lives of PWDs.

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Authors' contributions

M.R. and R.L. equally contributed to the research and writing of this article.

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