

THE DAWN OF A NEW EPISTEME: PROPOSING A NEO-BIOPSYCHOSOCIAL UNDERSTANDING OF DISABILITY

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ABSTRACT

Without any doubt, the social model of disability brings a revolutionary ontology and epistemology in defining what causes disability in the lives of individuals living with some form of impairment and chronic illness. However, the social model of disability is not free from criticisms and variations. Within almost five decades after the introduction of the social model of disability, many scholars come out with new models and theories under the umbrella of disability studies. This concept paper shares part of the progress of our theoretical project in producing a new grand theory of disability which we call the neo-biopsychosocial model of disability by integrating, rearranging and refining the existing models and theories in this field. We argue that a disability model or theory should fulfill three basic characteristics which are: (1) Clear definition or operationalization of its terminologies or concepts; (2) Clear explanation of the dynamics of and relationships between elements, components or concepts; (3) Potential practical solutions or uses. Afterward, we present the general theorem of disability which builds on principles of interrelatedness, intersectionality, diversity, the notion of change, universalism-specialism dichotomy and optimistic/realistic idealization. We redefine disability as a lifelong process of having to face or not to face barriers and risks of barriers caused by negative relationships between self, society, and environment due to inaccurate episteme which then leads to abstract and material inequalities in disabled people's lives. We conclude by discussing some implications from the proposed model on disability research production, disabled people's advocacy, and their empowerment. Through this paper, we hope to encourage critical debates for the liberation of disabled people locally and globally.

Keywords: Disability, definition, models and theories, neo-biopsychosocial, episteme.

INTRODUCTION

Like in other disciplines, disability studies has developed so much in terms of its theories and models. Disability, as stated in the preamble of Convention on the Rights of Persons with Disabilities, is a developing concept (United Nations 2006). Agreeing to Oliver's (2002) concern, disability should be viewed beyond the medical model of disability and charity-based approach. It is very fascinating to see a range of models and theories of disability emerging from many schools of thoughts such as critical theories and posthuman studies. If we look further back, we can also witness the variations of the social model of disability as well as its criticisms.

We write this paper to share a part of our mental project in redefining, rearranging and rebuilding model of disability. Before such discussion, we shall map the emergence and development of models and theories of disability. Then, we put forth our idea of basic characteristics and concerns of a disability model or theory. From there, we shall present our definition of disability and its basic principles. We shall also discuss the entanglement between different dimensions in the proposed model. Finally, we try to draw up some potential contributions from the proposed model on disability research praxis, disabled people's empowerment, and their advocacy.

It is said that disability studies is under-theorized and under-methodologized (Soder 2009). There are also some scholars who question the usage of the social model of disability, especially in research praxis (Baker 1999; Danieli & Woodhams 2005). We hope the present paper can offer some solutions to remedy the shortcomings of the social model or at least open the door for us to rethink about disability and its dynamics.

MAPPING THE CONCEPTUALIZATION STREAM

The driving force behind the evolution of disability conceptualization is thought construction, deconstruction, and reconstruction. This is the basic process of any model, theory, and philosophy development in this world. The same can be said in disability studies. These construction, deconstruction and reconstruction are caused by the realization and shift of one's viewpoint through the interrogation of one's own experience or others'. For instance, many scholars attempt to recontextualize certain theories from several fields into the context of disability. Those fields include political theories (Arneil & Hirschmann 2016; Kimberlin 2009), anthropological theories (Reid-Cunningham 2009), and social theories (Goodley, Hughes & Davis 2012).

Disability, as Bury (1996) discusses, is a subject of socio-medical research in the United Kingdom and the United States before shifting to a redefinition of disability as a form of social oppression. Before the introduction of the social model of disability in the 1970s until 1990s, disability is predominantly a medical issue since impairment and/or chronic illness fall under health issues. When the Union of the Physically Impaired Against Segregation (UPIAS) produces a document in 1976 which then becomes the basis of the social model of disability, two modes of thinking emerge, categorizing the medicalization of

impairment/chronic illness as a medical model of disability, whereas the social oppression approach becomes the framework of the social model of disability. The medical model of disability or some call it as 'individual' or 'personal tragedy' model of disability, is criticized for its focus on individual deficits and medicalized approach to make one so-called 'normal human being' (Oliver 1990). The medical model of disability exhibits the 'mechanistic view on the body' which assumes direct causal relationships between the health condition, health care and individual's capacity (Waddell & Aylward 2010, pp. 8-9). In this model, a cure is the only solution for one to get back to a normal life (e.g. work, learn, and procreate), but failure to positively respond to the cure leads one to be deemed as having 'long-term incapacity'.

On the other hand, the social model of disability abolishes the linkages between impairment/chronic illness and disability. As more evidence has shed light on the relationship between disability, social exclusion, and poverty, many disabled scholars like Vic Finkelstein and Mike Oliver argue that disability is caused by able-bodied system imposed on to the disabled people, thus shift the focus from individual to society as well as the emphasis for empowerment of disabled persons (Waddell & Aylward 2010, pp. 13-14). As many other earliest scholars such as Oliver (1983) and Barnes (1985), Abberley (1997) also views disability as oppression. He suggests that:

"(1) recognises and, in the present context, emphasises the social origins of impairment; (2) recognises and opposes the social, financial, environmental and psychological disadvantages inflicted on impaired people; (3) sees both (1) and (2) as historical products, not as the results of nature, human or otherwise; (4) asserts the value of disabled modes of living, at the same time as it condemns the social production of impairment; (5) is inevitably a political perspective, in that it involves the defence and transformation, both material and ideological, of state health and welfare provision as an essential condition of transforming the lives of the vast majority of disabled people." (Abberley 1997)

The social model of disability has been discussed in relations to many phenomena such as madness (Beresford 2004), psycho-emotional dimensions (Reeve 2004), strategic alliance with non-disabled persons for inclusion (Tregaskis 2004), and higher education (Brown & Simpson 2004). For instance, using the tripartite structure of terminology development that based on the social model of disability, Bolt (2005) proposes the shift of the term blindness to visual impairment follows three phases, which are ableism, disablement, and impairment.

Though at one time Shakespeare and Watson (1997) defend the social model of disability, they too have reanalyzed and repositioned themselves in terms of disability theorization (Shakespeare & Watson 2002). They discuss two main criticisms of the social model of disability. First, the social model of disability fails to recognize the impact of one's impairment and/or chronic illness, hence dismissing altogether the experience caused by one's impairment/chronic illness, either positive or negative. This argument also shared by several other scholars such as Crow (1996), Johnston (1997) and Pinder (1997). Secondly, they assert that impairment/disability is not a dichotomy. Rather, a continuum which continuously interplays in a disabled persons' lives. The same argument is made by Garland-Thomson (2011) as she introduces the term 'misfit' from the perspective of feminist disability studies.

The discussion by Waddell and Aylward (2010, p. 14) in their book best summarizes the shortcomings of the social model of disability:

"... downplays understanding of the individual's health condition, and takes symptoms and disability at face value ... generally ignores personal/psychological influences on illness, sickness and disability ... fails to consider interactions between the person, health and social context. The social model applied to sickness. The social model is generally used in the context of 'disability', but may be applicable to sickness, particularly with mental health problems. Common mental health problems often involve problems with social relationships, at work and elsewhere. Social relationships, by definition, involve two (or more) parties. Consideration of individual behaviour must therefore be balanced against the behaviour of others."

Debates on the dichotomy between the social model and the medical model have been and continue to be contentious. As a result, the third wave of disability ontology emerges through the introduction of the biopsychosocial model of disability. This is an effort to harmoniously reconcile the two opposing models when the World Health Organization introduces the International Classification of Functioning, Disability and Health. In fact, the Convention on the Rights of Persons with Disabilities also enshrine the same conceptualization when defining disability as follows:

"... disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others" (United Nations 2006)

The biopsychosocial model of disability argues disability encompasses the interaction between biological, psychological, and social dimensions which in turn promotes the individual-centered approach (Waddell & Aylward 2010, p. 23). Though the social model of disability arguably gains more popularity in today's world, the medical model persists to challenge it which presents continuous ideological contestation, suggesting the co-existence of the two in a parallel historical context (Hedlund 2000, p. 779). The consciousness of the interplay of these discourses is in line with Shakespeare's suggestion for the disability studies to adopt critical realist paradigm (Shakespeare 2014).

Samaha (2007) asserts that the social model of disability has no policy implication due to the absence of explanation of which policy framework to use (e.g. libertarian, utilitarian or egalitarian), and its inability to recognize the link to institutional design and its inability to supply appropriate response to controversies relating to genetic screening technology, cochlear implants, and sign language communities. As change is inevitable in human life, the social model of disability also needs to be reconstructed and reformulated with more research invests on interpersonal experiences of living with impairment, contextualizing in a historical, social and cultural setting and the employment of ethnographic and other qualitative methodologies (Watson 2004).

Thomas (2003, 2004a, 2004b) offers plenty of groundbreaking thoughts when she advocates for a social relational model of disability, which she bases on four themes:

- (i) The position and relations of disabled persons within an economic context, looking back from pre-capitalist to the capitalist period which in turn causes us to investigate the political economy of disability;
- (ii) The psycho-emotional relations in disabled persons' lives, contextualizing in familial relationships and interpersonal interaction with others (see also Reeve 2004);
- (iii) Engaging with the sameness and differences within the disabled community, and between the disabled community and non-disabled community, through theorization on different fields of disability studies (i.e. feminist disability studies, queer disability studies etc.); and,
- (iv) Interrogating the socio-biological relations of disabled persons to the concept of impairment and impairment effects through cross-disciplinary ventures between disability studies and socio-health fields such as social epidemiology and medical sociology.

From a different corner of perspective, Dewsbury and colleagues (2004) propose an anti-social model of disability. To them, the failure of human being utilizing technology to support persons with impairment is the cause of disability. They believe that technology plays a key role in disabling or enabling one's life. Departing from the conception that bases on material viewpoint, Gabel and Peters (2004) alternatively argue for a shift towards resistance theory of disability. They propose such shift because of long historical endeavor of disabled community resists against disableism. We can understand the logic behind this proposal. Disabled people have long resisted the rigid and perfect notion of normality imposed by society and against material inequalities which exist in form of inaccessible buildings, patronizing portrayal in media and so on.

Within the past two decades, there is emerging work that refocuses disability issues toward promoting and embracing the positive values of impairment/chronic illness. Developing their argument from the perspective of disability art and culture, Swain and French (2000) criticize the social model of disability of not acknowledging the positive aspects of having an impairment in which they propose an affirmation model of disability based on a non-tragic view. The same aspiration is also reflected from Wehmeyer's (2013) edited book (see the book review by Ayers & Weber 2014).

Recently, Goodley and his colleagues (2014) explore the possibility of posthuman disability studies. Basing their work on Braidotti's (2013) work, they discuss the broad relationship that one has with technology, other species (especially animals) and death. This groundbreaking work offers us a new paradigm that encourages us to rethink and reposition ourselves in a huge network of interpersonal and intrapersonal relations. Reading their work made us so excited and ashamed at the same time for not realizing this truth from the beginning. We, human beings including the disabled individuals have always been in this vast network of relations. This pushes us to rethink some of the controversial questions in the disabled community such as eugenics, normalization, and assisted-death.

We start this endeavor is not to simply condemn the social model of disability. The social model of disability exposes material inequalities and dominant values on people's body and mind. It pushes us to engage at the margin. Agreeing to what Oliver (2013) has said before, criticizing and disassembling the social model of disability should come up with a more meaningful conception. Not to satisfy one's intellectual ego. Rather, committed to finding new effective ways to emancipate the disabling condition that the disabled community is in, especially in the era of austerity and economic uncertainty. This paper, we hope, can offer what aspired by Oliver (2013), in finding the truth, advance our understanding of the phenomenon and produce meaningful praxis and politicization of disabled people's liberation from their life struggles.

THE BASIC CHARACTERISTICS

We would like to argue that there should be three main characteristics of any model or theory of disability, regardless of its origin in any schools of thought or camp in disability studies. These three characteristics are prerequisite or the basis to a model or a theory. Those characteristics are: (1) Clear definition or operationalization of its terminologies or concepts; (2) Clear explanation of the dynamics of and relationships between elements, components or concepts which underlie the model or theory; and finally, (3) Potential practical solutions or uses of such model or theory in bringing change to disabled people's lives.

In any model or theory of disability, there should be a clear definition or operationalization of basic concepts such as the term impairment and disability and other concepts that serve as building blocks of that particular model or theory. In addition, there should be a justification or reasoning of such definitions or operationalization. For example, if the theory views impairment and disability as the same, the theorist should justify his or her position of such argument.

Secondly, a model or theory of disability should also explain the mechanics or relationships between concepts used. The question of 'how', 'when' and 'why' should be answered here. For instance, if one is trying to conceptualize a model of disability from a technological standpoint, one should, first clarify the terms he or she uses (e.g. impairment, disability, and technology), then elaborate on the relationships exist between the concepts. How technology solves or creates disability? Why impairment is a vital variable to technological advancement?

Lastly, a model or theory of disability must possess, or the very least have a possibility of producing practical measures. This stand stems from our belief that theory and research should have strong linkages to material change as argued by Hosking (2008) or labeled as 'materialist' by Shakespeare (2015). In our opinion, theory or research does not only serve the thirst for challenging philosophical revelation. But, it should be committed to bringing change into the real world.

THE BASIC THEOREM

From the streamline of models and theories development and combining with the three main characteristics we laid out above, we shall now propose a general theorem of disability conceptualization. Breaking away from universalistic view, this theorem outlines the main issues, concerns, and challenges in any disability conceptualization. This theorem is set up by a number of principles as follow:

- (1) Interrelatedness: It is illogical to view that concepts such as impairment, chronic illness, disability, and others do not relate in one way or another. We must realize that these concepts have some form of relationships, either positive or negative, as one complex phenomenon. These relationships show how these concepts react to each other, or influence one another. These concepts are integral, mechanical and dynamic in nature.
- (2) Intersectionality: Disability is not an isolated phenomenon, only encompassing issues relating to impairment or chronic illness and social construction towards those conditions. Rather, disability is a multi- and intersectional issue that overlaps with other biological factors such as gender (Morris 1992; Soder 2009); ageing (Burchardt 2004) and race (Vernon 1997), plus multiple life dimensions (Efendi, Fadzil & Khoo 2018) such as economics, social, culture, politics, sexuality, parenthood, technology and environment. The interplay of multiple dimensions produces “negotiated identity” that opens up to various directions for research, theorization, and praxis (Kraus 2008).
- (3) Diversity: The disabled community is inhomogeneous. Disabled community not only comprises of persons who have a physical, sensory, intellectual and mental impairment but also consists of those who are living with chronic pain and illness. There are also persons who have multiple impairments and persons with an impairment which also lived with chronic pain or illness. There are even different degrees of impairment, from mild to severe, resulting in different degrees of biological functioning amongst the members of this community. Some may have episodic pain or limitation from one’s impairment/chronic illness, while others may feel continuous pain throughout their lives. So, a model or theory of disability cannot only explain the disability narrowly on certain groups of persons with impairment/chronic illness and overlook the experience of other groups of persons with impairment/chronic illness.
- (4) The notion of change: The notion of change is always, and should continue to become an inherent part of any model or theory of disability, whether the theorists express it explicitly or otherwise. The weakest notion of change can be seen from the philosophical revelation, moving from one point towards more positive or empowering conceptions. While the strongest notion of change can be seen from the practical solutions offered explicitly in a model or theory. This is not to say the latter is better than the other. Instead, we argue that the notion of change is an inherent part of a model or theory.
- (5) Universalism Vs. specialism: These two concepts, universalism and specialism, though some people may not realize it, are also parts of any model or theory of disability, either in the thinking process or as final outcomes. On one hand, this duality may offer diverse approaches to emancipating disability, while on another angle, this is also a dangerous dilemma to a theorist or even to the public sphere. We must remember that disabled persons are part of society. Thus, we must avoid from cutting them out or isolating their issues as just their issues. We should also be mindful of exclusionary thinking and measures we may impose or produce from our research and theories. In our opinion, an inclusive environment composes of both elements harmoniously. It is not about choosing one than the other. Instead, we need both measures.
- (6) Optimistic idealism Vs. realistic idealism: Idealism is the final issue in any model or theory of disability. A theorist may want to picture the conditions perfectly, while the other envisions a change perfectly. We are not here to illustrate any fallacy or pass judgment on a particular theory or model of disability. Regardless of the paradigm one may subscribe to including those who position themselves as a critical realist (like what we are trying to do here), one is obviously upholding some form of idealism because either we want to stay true to that particular approach or try to produce something from it. The two concepts above, optimistic idealism and realistic idealism, are the reflection that one will encounter throughout his or her theorization or during research. Nonetheless, the commitment to disability emancipation should remain the same.

RESORTING AND REBUILDING A COMPLICATED PUZZLE

To be frank, our job is quite easy. Previous scholars have provided us with a bulk of knowledge, reconceptualization, and reflection. Therefore, we cannot take all the credits for proposing the following model. Despite rich and diverse theoretical foreground, we realize there is a need for us to reflect and redeveloping the definition of disability. Let us begin by offering a new definition of disability as follows:

Disability is a lifelong process of having to face or not to face barriers and risks of barriers by persons with impairment and/or chronic illness, caused by negative relationships between the dimension of self, society, and environment based on inaccurate episteme which then leads to material and abstract inequalities in their lives.

We can trace four key phrases in the statement above: (1) Barriers and risks of barriers; (2) Caused by negative relationships between the dimension of self, society, and environment; (3) Based on inaccurate episteme; and, (4) Material and abstract inequalities in their lives. Before we explain further about the statement above, we must abide by our own rules, operationalizing all concepts involved. Basically, there are five more concepts mentioned in the statement above; impairment/chronic illness, self, society, environment, and episteme.

Impairment and chronic illness refer to biological and/or physiological lacking, limitation or failure possessed by a person resulting in her or his bodily, sensory, intellectual or mental limitation. The effect of an impairment or chronic illness only on one's biological functions associated with that particularly affected body parts, sense or organs. For example, a person who is blind only possesses limitation on his or her sight, and not other social functions such as reading, learning and moving around. However, one's impairment or chronic illness does reflect one's risks of barriers if his or her needs are not being addressed accordingly, which in turn producing disability onto that person. For example, persons who are deaf or hard of hearing has limitation to listen to audible signals. But, they can still communicate with others using sign language or writing. On that point, the society must provide education of sign language and writing skills to that person besides providing sign language interpretation services and hearing aids for those who are hard of hearing. Failing to do so will produce disability to this group.

Impairment and chronic illness as we explained above, will have negative effects on one's biological functioning in certain conditions and contexts. Sometimes, impairment may have benefits to the owner too. For instance, a person who is blind can read in the dark or a person who is deaf does not have to deal with sound pollution. The benefits and pain of one's impairment or chronic illness exist in a continuum. For some, the impairment comes along with episodic pain. This is true for those who suffer glaucoma. Therefore, we should not dismiss the benefits and pain experienced by a group of persons with impairment/chronic illness.

A biological deficit can also impact one's social functioning. If the risks of barriers are not being addressed effectively, it may amplify the negative effects of one's biological dysfunction which then interrupt one's social functioning. For instance, for a person who has bipolar depression may at one time socially function (e.g. go to work, attending a lecture or prayer and playing with his or her child). But, in another time, due to his or her mental health problem, they cannot fully meet their social functions (e.g. he or she won't talk, moody etc.). In this case, he or she needs support, either socially, emotionally or medically. Though one's impairment/chronic illness is an integral variable possessed by oneself, it is certainly not the only factor. Self encompasses others' biological, social and cultural traits that one has.

Self refers to biological, psychological, emotional, social and cultural ownership that one has. These include biological characteristics (impairment and/or chronic illness, gender, race, and age), psychological characteristics (motivation, locus of control, stressors, personality and self-concept), emotions, social background (level of education and economic status) and cultural stands (such as religion, worldview and values). These components interact with each other, resulting in different relationships within different settings, context, and life course. Though we establish a concept of self, this dimension has a trilateral relationship with the society and environment which one belongs to. Self can influence society to react to the components in oneself and vice versa. The same process also happens in self-environment interaction.

Society refers to a set of system which consists of different institutions and groups of actors that a person with impairment/chronic illness belongs to and at the same time opposing against. There are a number of institutions with each institution has different actors. The encounter between society and persons with impairment/chronic illness are inevitable, even when persons with impairment/chronic illness are forced or regulated to live in isolation. Those institutions are the family institution, social institution, cultural institution, political institution, labor market and the community of persons with impairment/chronic illness and their organizations.

The components of self trigger various forms of response from individuals in one's surrounding. The response, either negative, positive or even 'supra-positive' (Nasir & Hussain 2016) in nature, exists in forms of actions and language. The lingual response includes labeling, portrayal in media or other forms of arts, terminologies relating to conditions (e.g. changing the word of impairment to other so-called more appropriate terms), and processes involving persons with impairment/chronic illness (i.e. branding or naming certain process of including or segregating these persons). We are not against labeling since one's label of impairment/chronic illness reflects one's needs and risks to better inform others of necessary adjustments. But, labeling also has the potential to transform into stigmatization and lead to discriminatory actions. An action-based response, on the other hand, occurs when institutions and those who have power on those institutions impose something or react in some way towards persons with impairment/chronic illness. Such response exists in form of legislation, access, commodity and capital (including social and human capital).

Moreover, different institutions work together either in an organic or in a mechanical manner. Like different components in self, these institutions too interact with and influence each other, hence producing a set of system. As such, values, perceptions, attitudes and actions toward persons with impairment/chronic illness can be transmitted from one institution to another, from one actor to another, which eventually form common values, perceptions, belief, attitudes, and action—episteme. This episteme will affect how the society utilizing the environment when dealing with persons with impairment/chronic illness, and also affect the self-concept formation among individuals with impairment/chronic illness.

We use the word 'system' because these groups of people in these domains are in charge of regulating their domains and producing tools for that matter. Society is responsible for creating and regulating the environment using different forms of tools at their disposal. The environment then refers to different tools created by society in facilitating their daily lives such as policies, laws and regulations, technology, infrastructure, and even the animal and natural surrounding. In this context, society creates the function of a certain animal, breed and train them such as dogs. The society decides on how to transform a piece of land or to adapt to its features in order to build a structure on it. These tools also have bilateral relationships to self which these two domains influence each other. This trilateral relationship between self, society, and environment are driven by episteme. Borrowing Foucault's work and expand on it, episteme in this model refers to belief, knowledge, and perception that shape a person's and/or the whole community attitude in the forms of speech and actions toward these three domains.

We consciously make a clear separation between the term ‘disability’ which means barriers and risks of barriers, and the term ‘impairment’ or ‘chronic illness’. When it comes to defining disability, we are adopting the core statement of the social model of disability, which is barriers. We just extend it by adding ‘risks of barriers’. Here, risks of barriers mean barriers that can exist or persist if the needs of persons with impairment or chronic illness are not addressed accordingly. This clear separation is important. Disability is not impairment/chronic illness. Nevertheless, impairment/chronic illness is amongst many variables that can shape one’s disability. We recognize that impairment/chronic illness and the experience from such conditions are an integral part (Hosking 2008; Johnston 1997; Pinder 1997; Shakespeare & Watson 2002) of many variables alongside societal and environmental variables and establish relationships to disability. Disabling relationships between these three dimensions (self, society, and environment) causes barriers and risks of barriers (disability).

This disabling relationship rooted in negative episteme possessed by a person and a community. Within this trilateral relationship, disability can exist in various ways such as:

1. When society deems one’s impairment or chronic illness as unfit and incapable, resulting in disablist speech, actions, and rules that hinder persons with impairment/chronic illness to actively contribute in their family decision making, voting in an election, enrolling in the field of studies of their choice, getting gainful employment and so forth.
2. When policies, laws and regulations, technologies and infrastructures do not take into account of the needs and voices of persons with impairment/chronic illness, and when certain policies, regulations, and legislation put certain provisions that prohibit the function and participation of people with impairment/chronic illness.
3. When a culture prohibits the use of guide dogs in personal and/or public settings.
4. When disabled people’s movement fails to acknowledge the diverse background of its members and finding commonalities between them which resulting in a narrow form of advocacy.
5. When a person with impairment/chronic illness acts negatively, or giving a negative impression to the society, leading to unfair stigmatization or over exaggeration among society.

On the contrary, accurate episteme facilitates enabling relationships between those three dimensions which in turn bringing inclusion and empowerment to persons with impairment/chronic illness. Thus, to nurture accurate episteme, civil activism, awareness campaigns, education, and proper socialization are amongst the strategies to consider. However, we are very aware, disability as a complex phenomenon is not simply black and white matter, correct and false binary. More often than not, positive and negative relationships between the aforementioned domains occur simultaneously. Therefore, one may face disability in one aspect, but feeling empowered in another. A person with certain impairment/chronic illness may receive more positive support than persons with another type of impairment/chronic illness may not. It can also happen where a person with impairment/chronic illness receive ignorant comment from one actor in an institution but gain social acceptance from a different actor in the same institution.

The neo-biopsychosocial model of disability brings forth a multi-relational paradigm. It tries to fill the gap in connecting the macro setting to the micro experiences. The neo-biopsychosocial model of disability encourages us to investigate a conflict from a broader perspective, but at the same time do not neglect the different smaller aspects. This new arrangement of consciousness calls for reengagement with the subject of human rights, disabled people’s identity, normalization and may also produce a new political paradigm for governance and policymaking.

IMPLICATION FOR RESEARCH PRODUCTION

The model we proposed above is not an effort to either oversimplify disability as a phenomenon or make it so pedantic and confusing. When writing this paper and explaining this new grand theory of disability, we consciously position ourselves in a critical realist paradigm or at least trying to adopt its philosophy. And we would like to argue that the proposed model above has its potential contributions in disability research production. From one angle, the model repositions disabled persons and re-engage this minority group in their relationships with their ‘self’, different sectors in society and various tools in their surrounding.

From this, if we may use the term ‘reformed’ ontology, it opens to a new, unique and creative epistemology and methodology. For example, in the model above, we argue the bilateral relationships between disabled individual’s ‘self’ and the society. From this dynamics, we can identify multiple sources of data (e.g. family members, politicians, civil servants, employers, religious figures and so forth). This will also reflect onto the research process. Besides encultures different methods of data collection as proposed by Stone and Priestley (1996) and Eckhardt and Anastas (2007), this new grand theory of disability also promotes critical and plural epistemologies and methodologies as argued by Hughes (2007) and Baker (1999).

IMPLICATION FOR DISABLED PEOPLE’S ADVOCACY & EMPOWERMENT

We would also like to make the case for the benefits of this model in disabled people’s advocacy and empowerment. There are several points that disabled activists and Disabled People’s Organizations must take note:

1. Impairment is part of human nature and human diversity as thoroughly discussed by Shakespeare and Watson (2002), Burchardt (2004) and Sutherland (1981). Thus, all persons with impairment/chronic illness are normal.
2. Expanding the first point above, disabled activists and their organizations alongside academicians and other allies who support the movement must take the ownership of redefining all terms usually associated with the medical

model of disability (e.g. medicalization, normalization, rehabilitation, adjustment etc.) to become empowering concepts for the disabled community and their families.

3. Disability is a multi- and interdimensional, dynamic and intricate phenomenon that encourages us to view and solve it in a more broad and pragmatic way.

CONCLUSION

This new grand theory of disability, which we call as the 'neo-biopsychosocial model of disability' defines disability as a lifelong process of having to face or not to face barriers and risks of barriers by persons with impairment/chronic illness due to negative relationships between the domains of self, society, and environment. We argue that inaccurate episteme possessed by a person and the community is the root of the negative relationships which lead to disablement. We operationalize related concepts in this model and discuss the relations that exist between those concepts. Centering on the multi-relational paradigm within this model uncovers the new horizon in locating and emancipating disability.

We do not claim that the model proposed above has been perfected. It is still very much in the development phase. This model is a product from our accumulating knowledge, experience, reflection and observation in this fascinating field. We are eager to continue this journey and looking forward to the discussion or debates on this new agenda for disability theorization, both at the international and local stage. As the title daringly suggests, this is the new grand theory of disability. Again, we cannot take all the credits in proposing this model since all of its components and linkages have been discussed by many scholars before us. We are here to refine and produce, which we hope, a comprehensive and holistic model of disability.

Before ending this paper, we also present potential contributions of this model in terms of disability research production, disabled people's advocacy, and their empowerment. It is our hope that, with this paper, we can spark and nurture critical exploration on disability in the local sphere, as well as globally. We also hope to introduce critical realist philosophy in local academia which we feel suitable for local praxis, either in research or policy development.

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