Individual and Social Model of Intellectual Disability in Teachers' and Students' Beliefs

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Abstract: Author's research discussed in the following article was aimed at determining which model of intellectual disability is preferred by teachers and students, and what the differences are between these respondents in this respect. The assumptions characteristic for the individual model focused on the person with disability, and in particular, on his or her biological (physical) defects. The defects that caused limitations in functioning were treated as the basis of disability. Professional activities (mostly medical) focused on adjusting to the state of limited functioning, seen in a reductionist way: as accepting the loss of ability or independence. The social model situated the origin of disability in society. In this perspective, it defined disability as the product of specific social and economic structures, and its main interest focused on the problems of oppression and discrimination of persons with disability. Research was carried out with special needs teachers who work with individuals with intellectual disability, teachers working with able-bodied individuals, and students of special pedagogy. The Likert type scale, called "The model of an intellectual disability", was used to determine the model of intellectual disability. The research had a cognitive goal but also a significant practical goal related to the specialists' professional training. The article offers general recommendations for shaping attitudes and assessments connected with noticing possibilities in the lives of individuals with intellectual disability, taking into account the influence of environmental factors.

Keywords: Special needs teachers, teachers, social attitudes, moderate and severe intellectual disability, mild intellectual disability.

INTRODUCTION

A model of disability is, according to some authors, a paradigm, theory, and doctrine, according to others, an ideology and principle [1]. S. Gabel and S. Peters [1] believe, and quite legitimately, that a model is set within paradigms, thus it is narrower in its scope than the paradigms. Models are used to explain and organize sets of activities and tools which test (check) and deconstruct theories. They are rarely based on selected theories, more often they are grounded in many of them. They should not be judged in terms of truthfulness and falseness, only in terms of usefulness and adequacy [1]. Models of disability (the most frequently distinguished: individual, and social model) received considerable attention in numerous studies whose main objective was to subject them to critical analyses, usually comparative ones. It should be noted that some researchers and theoreticians claim that these two models are insufficient to describe ways of conceptualizing the phenomenon of disability from the social or individual perspective (mainly from the perspectives of specialists, and individuals with disability), therefore, they offer more detailed approaches to the subject [see 2, 3]. In the following paper, analyses will be limited to the traditional models

because of the specifications characteristic of Polish literature and practice. The individual model, also known as the medical model, relies largely on the conceptual category of impairments to explain the nature of disability, claiming that these impairments create difficulties in fulfilling tasks and roles, and participating in various spheres of life. Disability is a consequence of impairment and the aforementioned difficulties; it is a personal problem (personal tragedy) which should be tackled by means of activities focused on the individual. This model was developed in the times when medical service dominated, which was visible in how institutions, created to realize various goals (not only treatment and rehabilitation, but also care), operated. It included elements of the medical approach to a human being, unique for those times: treating people like objects, and the primacy of the physical sphere over all the others. How did the medical (individual) model apply to individuals with intellectual disability (mental retardation)? Several aspects pointing to an explanation and treating this type of disability in categories specific for the discussed model can be mentioned here (1) primacy of specialists in medicine (doctors, including psychiatrists) who make diagnoses (2) biologization of causes, and negligence of the significant role of environmental factors (3) genetic determinism (4) ignorance of developmental potential (5) prevalence of activities focused on treatment [see 3, 4]. In this way of understanding the nature of intellectual disability it was vital, for a

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significant period of time, not to distinguish intellectual disability from the medical category of mental illness.

The social model, as it is thought, developed from the criticism of the individual model present in the discourse of individuals with disability. This is surely a simplification, since perspectives for change were broad and embraced socio-cultural, economic and political aspects. The social model cannot be seen solely as a negation of the assumptions of the individual model, even though it drew attention to its problems with application. More importantly, it should be noted that in its conceptualization of disability, the individual model underestimated social factors (as a consequence of biologization, so characteristic of this model), not only the so called social barriers, but also social relationships of individuals with disability, the nature of their socialization, and the significance of social factors in adapting to disability. It also neglected the issue of socio-cultural factors, which are important for interpreting the significance of specific deficits in health and physical fitness. Biologization and related to it medicalisation of the professional approach led to overestimating limitations and underestimating potential; consequently individual potential was not taken advantage of, and dysfunctions were treated as determinant of human capacity (e.g. in education). What is also noteworthy is how support is organized with its prevailing institutional and segregation solutions [Knoll, in 5].

In the social model, the essence of disability lies in complex mental and material barriers. Disability results from insufficient service and inadequate organization of society [6]. One of the more important mechanisms which determine the way individuals with disability function is oppression in the forms of: exploitation, marginalization, discrimination, cultural imperialism, and violence [see 3, 7]. It is precisely this oppression that individuals with disability stood up against. Their actions not only stimulated the creation of the social model, but they also established it. Oppressive activities begin when "otherness" is recognized; this recognition relies on socio-cultural factors, and especially social agreements describing the so called normality in every sphere of human functioning. As soon as a deviation from norm (moral, or health norm) is identified and labelled (in the form of a diagnostic category, e.g. intellectual disability or mental illness), the process of social "disabling" starts [6]. Identification of dysfunctions and limitations is a complex process, depending on, among other things, their type and severity (which also influence the process of social

oppression). According to these assumptions, disability is a social construct. The definition of intellectual disability (mental retardation) is not an absolute, but a result of an agreement. The construct of disability greatly depends on social and cultural contexts, expectations and the level of social tolerance – and all of these change in time and space [Stroman, in 8].

Similarly to the individual model, the social model is not free from criticism which mostly pertains to suggested simplification and standardization. Perhaps, as it was already mentioned, this criticism results from an insufficient understanding of the assumptions of this model, which, in fact, is complex, and refers to financial and socio-cultural aspects [see 2, 6].

Modern ways of understanding intellectual disability differ depending on the environment, specific cultural conditions, knowledge and experience of the persons who represent it. Thus, we can speak of many kinds of discourses concerning intellectual disability: emancipation discourse, corrective-protective discourse, care-giving discourse, normalization and adaptation discourse [9]; human rights discourse located in the social model of disability, professional religious discourse located in the medical model of disability, community religious discourse contained in the community model, and interactive discourse [4]. Ways of understanding the essence of disability, and especially interpreting its causes and results (limitations and potential), are significant for designing and realizing professional and non-professional support, [see 7, 10]. This significance is visible on three levels (1) the level of specialists who, by accepting a given concept of disability, interpret and evaluate the needs of an individual with disability (2) the level of institutions and organizations where the specialists function; the values upheld there influence the process of creating concepts which are then accepted by the specialists (3) the level of society in general, on which the accepted values influence the institutions' and organizations' policies concerning disability [11]. What is also important, is that when individuals with intellectual disability develop ways of understanding their own disability, and form their own identity and self-image, they draw on ways of understanding this disability and attitudes towards it displayed by persons close to them (e.g. parents, caregivers, specialists) [9].

Author's study presented in the following part of the paper concentrates on the ways of understanding intellectual disability accepted by teachers, and students (who learn to become teachers). Teachers are

present in environments of education and rehabilitation which are as vital in the process of socializing individuals with intellectual disability as the family is. Their significance is visible in at least two ways (1) directly, by shaping psycho-social competences in individuals with disability (including the image of disability, and adaptation to living with it) (2) indirectly, by cooperating with the environment where individuals with intellectual disability live (their families) and influencing its members in the process of creating a certain way of understanding disability.

RESEARCH DESIGN

The research goal is to determine which model i.e. individual or social, describes the nature of intellectual disability according to teachers and students. The aim was to find out whether respondents' beliefs about intellectual disability, with its causes, results, needs and type of professional support, concur with basic assumptions of the individual or the social model of intellectual disability. The concept suggested by J. Kirenko [12] was used to operationalise the models, and on its basis, it was assumed that the individual model is characterized by accenting biological aspects of disability, deficits and limitations, and highlighting the importance of medical activities. The social model is multi-faceted in that it draws attention to a multitude of conditions for disability (focusing on the social ones), individualizing needs, potential and limitations; it emphasizes the need for a broad professional support.

It was assumed that the respondents' beliefs about intellectual disability are shaped in the process of gaining personal and professional experience (stereotypical views acquired in the process of socialization may play a role here as well). It may be expected, however, that these beliefs are corrected and changed during professional education. Anticipating the influence of various factors significant for shaping specific concepts of intellectual disability, three groups of respondents were created, differing in age and experience. The first group, students of special pedagogy, are persons preparing to work with individuals with disability. In the course of their education, they gain competences which allow them to learn about the nature of disability, but also shape specific ways of assessing disability (from the perspective of potential and limitations) and attitudes towards individuals with disability. In the course of their academic education they have a chance to use their competences during teaching practice which takes place in educational facilities, most often in special

needs educational facilities. The second group are special needs teachers who work in environments which are segregated (educational facilities for individuals with disability). These teachers are trained in special pedagogy and they are competent to work with individuals with intellectual disability. Performing their professional duties, in education and rehabilitation, they confront their academic knowledge with practice – they have a chance of reworking it through their personal experience. Their beliefs result, therefore, not only from acquired competences, but also from positive and negative experience: successes and difficulties in working with individuals with intellectual disability. The third group are teachers working in educational institutions which are open to all students, most of whom are able-bodied. This group of specialists do not possess broader competences for working with individuals with intellectual disability, though, in the process of their education, they may acquire basic knowledge of special pedagogy. Teachers do not usually work professionally with individuals with disability, and if they do, they do it in conditions which differ from those available for special needs teachers (in conditions typical of mainstream education). The nature of beliefs in this group is, probably, most heavily affected by stereotypical knowledge, selective experiences and observations.

Analyzing beliefs about the nature of intellectual disability, it is indispensable to specify its level, which is a differentiating factor as far as personal potential and limitations are concerned (assuming that the level itself, as a certain label, describes the potential and limitations, which are influenced by biological and social factors). Classification of individuals with intellectual disability, which takes place on the basis of the level of their disability, is used in education, social and professional rehabilitation, and social security. It is closely connected to principles guarding education and rehabilitation, and their consequences of realization: the forms and ways of life with intellectual disability. Traditionally, there is a division showing diversified life potential, mainly in terms of realizing social roles, and in dimensions of social functioning of individuals with mild and severe disability. It is confirmed by results of empirical research concerning the professional, and the personal sphere.

On the basis of the above deliberations the following research problems were formulated:

1.   Where are respondents' beliefs about the nature of mild intellectual disability more strongly set – in the individual model or in the social model?

2.   Where are respondents' beliefs about the nature of severe (moderate and severe) intellectual disability more strongly set – in the individual model or in the social model?

3.   Are there differences between the groups of respondents in terms of beliefs about the nature of mild intellectual disability? And, if yes, what are the tendencies in these differences?

4.   Are there differences between the groups of respondents in terms of beliefs about the nature of severe (moderate and severe) intellectual disability? And, if yes, what are the tendencies in these differences?

5.   Is the level of disability (mild – severe) a differentiating factor in respondents' beliefs about the nature of disability? And, if yes, what are the tendencies in these differences in each of the groups?

With no empirical evidence within the scope of this research no hypotheses were formulated regarding problems of diagnostic nature. Hypotheses were formulated for the third, the fourth and the fifth problem, assuming that the respondents, because of diverse educational and professional experience, will vary in their beliefs concerning the nature of mild intellectual disability. It was also assumed, without specifying the direction of the tendencies that differences will occur in the case of severe disability. Taking into account various potential and limitations determined on the basis of the level of intellectual disability, it may by hypothesized that there is as disparity in beliefs about mild and severe disability (problem 5). It seems that these differences will occur in all the groups, and their nature (tendencies) will be influenced by various factors, including the knowledge acquired during studies, or training (e.g. referring to literature on the subject), stereotypical knowledge and experiences. It must be emphasized that in Polish literature on the subject most characterisations of intellectual disability are based on the level of disability, and focused on lack or difficulty, not potential (negative characterisations).

METHOD

Diagnostic poll method and a questionnaire technique were used in the research. The research tool was a Likert type scale called "The model of an intellectual disability", which was used to determine the model of intellectual disability. This tool was designed specifically for the research project on pedagogues'

attitudes towards sexuality of individuals with intellectual disability and their correlates. Concepts of the individual and social model of disability described by J.Kirenko [12] and an instrument of his design were used as the basis for constructing the author's tool. The author's scale was validated, receiving values from 0.41 to 0.63. Cronbach's alpha coefficient obtained in a standardization tests for the scale falls between 0.68 and 0.74. The discriminatory power of questions varied from 0.20 to 0.57.

The scale consists of 12 statements, 6 of which refer to the individual model, and 6 to the social model. Respondents express their opinion using a 6-point scale (from 5 – I strongly agree, to 0 – I strongly disagree). The individual (medical) model of intellectual disability utilized the following conceptual categories: institutionality of living conditions, relying on others, biological determinism (damage to the central nervous system) in the genesis of the phenomenon, necessity to be subordinate in the process of support, inability to enjoy civil rights or fulfil civic duties, and medicalisation of professional support. The social model was based on: living in an open, natural environment, opportunity for autonomy, a variety of disability conditions, a possibility to participate in making decisions concerning support, a civic model of life, access to civil rights and civic duties, as well as the need for professionals of various fields to cooperate in support. Cronbach's alpha coefficient for the scale of individual and social model is above .70 (students, special needs teachers and teachers). The discriminatory power rating of the questions ranges from .20 to .52 (students), .20 – .65 (special teachers) and .29 – .59 (teachers) in individual model and .26 – .64 (students), .36 - .62 (special needs teachers) and .40 – .60 (teachers) in the social model.

Participants

422 respondents took part in the study (122 students of special pedagogy), 150 special needs teachers and 150 teachers. Average age of students was 21.98. 77.3% of students were women. 59 students (45.38%) live in cities, 71 (54.62%) in the countryside. Students are in the second or third year of their undergraduate studies in special pedagogy with their major preparing them to work with individuals with intellectual disability.

Average age of the special needs teachers was 42.69, average age of teachers was 42.68. Women were in majority in both groups (93.33% in the group of special needs teachers and 90.70% in the group of

teachers). Most respondents live in cities (76.67% of special needs teachers and 84.67% of teachers). All the respondents in both groups work in educational facilities, including kindergartens and schools. Special needs teachers work with individuals with mild intellectual disability (16%), moderate and severe (34%), and profound (6.7%), and individuals with various levels of intellectual disability (39.3%). In group B the mean work experience was 16.24 years, in group C, 17.02.

PROCEDURE

The research with student respondents was conducted at a university and university college in Lublin where the respondents study special pedagogy and pedagogy in their full-time, extramural, undergraduate and master's courses. Studies were conducted in university halls with the consent of the lecturers and students. Students received questionnaires and verbal instructions on how to complete them.

Research with teacher respondents was conducted on the premises of their workplaces. Each of the meetings required the consent of the institution's authorities. One of the conditions for receiving this permission was disclosing the research goal and problems, and giving access to the research tools. The second condition was the consent of the respondents, who were informed about the goal, and assured about the anonymity of the study. They were also advised that the results would be used only for the purpose of scientific research (this information was also given to the students). The questionnaires were given to the respondents through the hands of the authorities, psychologists or teachers working in the institutions, familiarized with the research problem and the way the research was to be conducted. The respondents filled in the questionnaires individually, usually at home. Most of the questionnaires were then collected within two weeks.

RESULTS

Mean scores obtained in all the groups suggest that both special needs teachers and teachers more strongly agree with items concerning mild intellectual disability characteristic of the social model (Graph **1**, Tables **1-2**). Responses to statements within the individual model fall between "Somewhat agree" and "Strongly disagree". Analysis of statements (Graphs **2-4**) suggests that respondents most strongly agree with

the social model which postulates participation of individuals with mild intellectual disability, and strongly disagree with their institutional living conditions. They approve of an egalitarian model of how this group of individuals with disability should function, which entails access to common civil rights and civic duties; and disagree (but not strongly) with statements that these individuals are not able to undertake their civic duties or enjoy their civil rights. Respondents, mainly special needs teachers, strongly agree with statements about the possibilities for individuals with mild disability to function autonomically, acknowledging the significance of environmental factors including socialization and support. Respondents disagree (teachers being less convinced) with items stating that individuals with mild disability rely on others for help. Special needs teachers most strongly agree that this group of individuals with disability require multifaceted support, disagreeing with the statement that support should focus on medical activities. Students and teachers also note that there is need of extensive support, though they are not so convinced about it – they only somewhat disagree with the statement about the domination of medical procedures. Respondents agree, though students and teachers not strongly, that individuals with mild disability should be included in the process of taking decisions on issues related to their own support. On the other hand, it seems that they have doubts, since they do not choose to strongly disagree with the statement about the incapability of individuals with mild disability to cooperate on issues of their own support. Respondents, especially special needs teachers, take an ambivalent stance on determining the etiological nature of this level of disability. They see mild disability as a polietiological phenomenon, and at the same time they do not strongly disagree with the item stating that this level of disability results from damage to the central nervous system (CNS). A similar ambivalence can be observed in students and teachers.

Similarly as in the case of mild intellectual disability, severe disability is analysed within the categories of the individual and social model (graph **5**, Tables **1-2**). A detailed analysis of statements (Graph **6-8**), including the nature of responses, suggests that respondents' beliefs about the nature of disability are ambivalent. Responses to items concerning the individual model spanned from "Disagree" to "Somewhat disagree", whereas for the social model, from "Somewhat agree" to "Agree". Within the social model of disability, student respondents are optimistic about this group's capacity
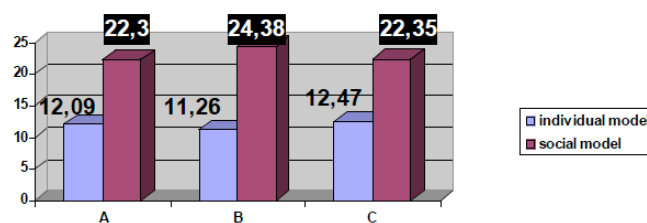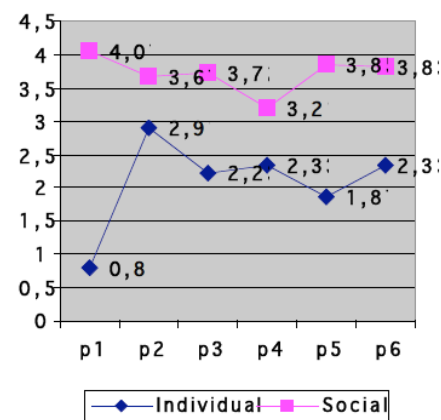
Graph 1: Respondents' beliefs on mild intellectual disability, mean values (A – students; B – special needs teachers; C – teachers) – mean scores.
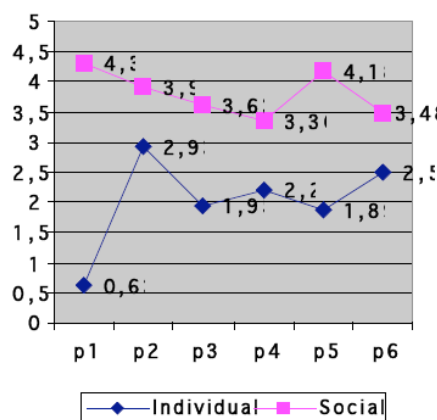
Graph 2: Statements in individual[A] and social[B] model of mild intellectual disability (A) – mean scores
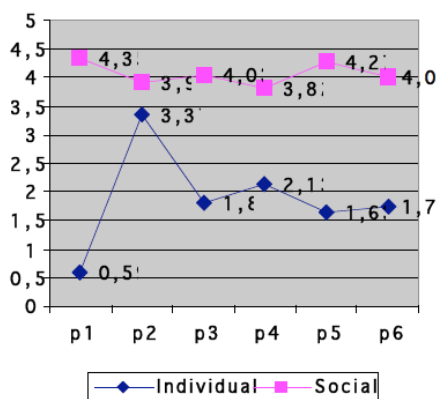
Graph 3: Statements in individual[A] and social[B] model of mild intellectual disability (B) – mean scores

Graph 4: Statements in individual[A] and social[B] model of mild intellectual disability (C) – mean scores
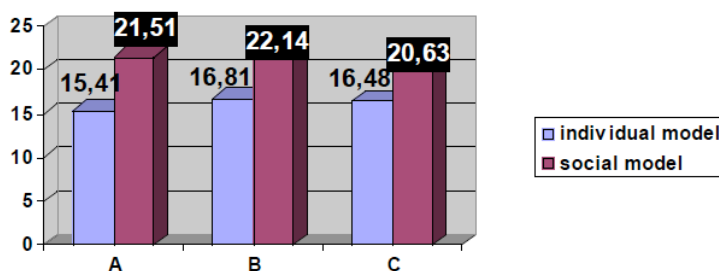
[A]Individual model: p1: An individual with intellectual disability should function in a closed environment (an institution); p2: Intellectual disability results from CNS damage; p3: Individuals with intellectual disability are bound to be reliant on others for help; p4: Individuals with intellectual disability are not able to take decisions on issues related to their own support; p5: Individuals with intellectual disability are not able to enjoy civil rights and fulfil civic duties; p6: Intellectual disability requires mainly medical intervention.
[B]Social model: p1: An individual with intellectual disability should be given natural open living conditions; p2: Intellectual disability results from complex biological, psychological and social factors; p3: With proper preparations and support individuals with intellectual disability are able to function more independently; p4: Individuals with intellectual disability should be included in the process of taking decisions on issues related to their own support to the greatest possible extent; p5: Individuals with intellectual disability are citizens, as we all are, and should be allowed to enjoy civil rights and fulfil civic duties to the greatest possible extent; p6: Support for individuals with intellectual disability requires cooperation between a number of specialists.

to function autonomously, on condition that they are provided with support and desirable socialization aimed at teaching life skills. Respondents from the other two groups, especially teachers, are less optimistic on this issue. The strongest inconsistency in beliefs can be observed in special needs teachers, who acknowledge the possibility of autonomous functioning and agree with the statement about constant dependence on others (reliance on others for help) at the same time. Special needs teachers and teachers are convinced that individuals with severe intellectual disability should realize the model of social inclusion, whereas students are slightly less convinced about it. Respondents from all the groups reject the model of institutional living conditions. Special needs teachers, and slightly less convinced students and teachers, agree with the need for extensive support, rejecting the statement that it should focus on medical activities. Ambivalence is also noticeable in the statements which concern the

aetiology of severe disability. Mean scores obtained in all the groups suggest that respondents see the complexity of factors which influence the emergence of this type of disability, but they do not reject the statement about biological determinism (CNS deficits as the predominant cause). This ambivalence is most clearly visible in the group of students. Respondents are inclined to believe that individuals with severe disability should be allowed to participate in making decisions concerning their own support. At the same time, they do not reject the statement that the same individuals are not able to self-determine on these issues. Similarly, they approve of the egalitarian model of life for this group of individuals with disability, but they doubt whether it can be implemented. A similar divergence between postulation and realization is very clear in teachers' responses.

An analysis to determine the differences between the groups showed that respondents differ in terms of

Graph 5: Respondents' beliefs about severe intellectual disability, mean scores (A – students; B – special needs teachers; C – teachers).
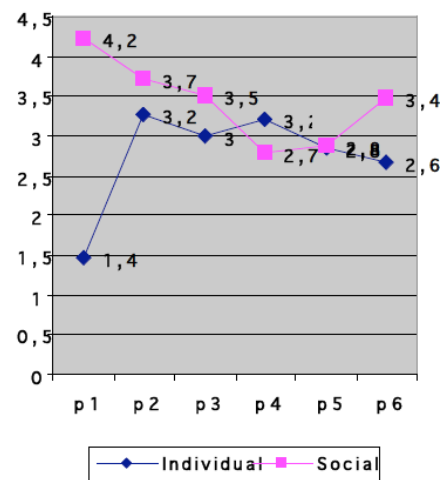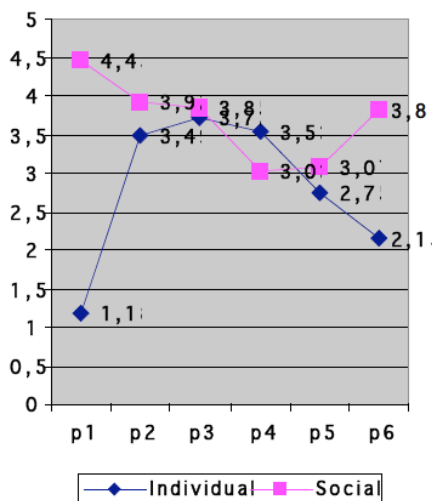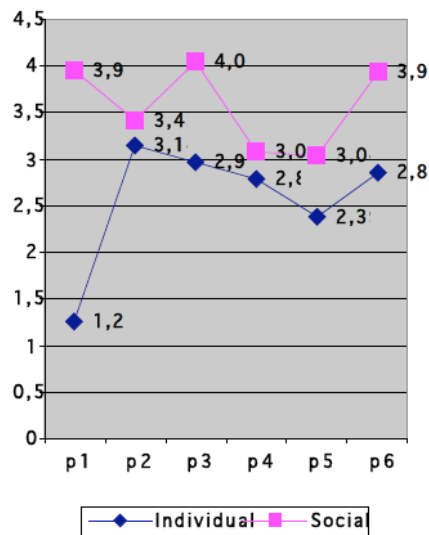
Graph 6: Statements in individual[A] and social[B] model of severe intellectual disability (A) – mean scores

Graph 7: Statements in individual[A] and social[B] model of severe intellectual disability (B) – mean scores

Graph 8: Statements in individual[A] and social[B] model of severe intellectual disability (C) – mean scores

[A]Individual model: p1: An individual with intellectual disability should function in a closed environment (an institution); p2: Intellectual disability results from CNS damage; p3: Individuals with intellectual disability are bound to be reliant on others for help; p4: Individuals with intellectual disability are not able to take decisions on issues related to their own support; p5: Individuals with intellectual disability are not able to enjoy civil rights and fulfil civic duties; p6: Intellectual disability requires mainly medical intervention.
[B]Social model: p1: An individual with intellectual disability should be given natural open living conditions; p2: Intellectual disability results from complex biological, psychological and social factors; p3: With proper preparations and support individuals with intellectual disability are able to function more independently; p4: Individuals with intellectual disability should be included in the process of taking decisions on issues related to their own support to the greatest possible extent; p5: Individuals with intellectual disability are citizens, as we all are, and should be allowed to enjoy civil rights and fulfil civic duties to the greatest possible extent; p6: Support for individuals with intellectual disability requires cooperation between a number of specialists.

the strength of their preferences for both models. Significant differences were found for mild and severe intellectual disability (Table **1**). Special needs teachers display the strongest beliefs about the social model of mild disability. In this respect they differ from the other two groups i.e. the students and the teachers. The teachers who work with individuals with intellectual disability agree less with the individual model in its explanation of the nature of mild intellectual disability. Students show the weakest belief in the statements grouped around the social model of mild intellectual disability. Teachers, on the other hand, most strongly of all the respondents prefer the individual model.

Significant differences between the groups were found in the case of severe intellectual disability (Table

1), especially in the quite inconsistent results obtained in the group of special needs teachers. This group is the one which most strongly prefers the individual and the social model. In the first case, significant differences were found in the groups of students and teachers, in the second case, the difference was found only between respondents in groups B and C. Students have weaker beliefs about severe disability set within the categories of the individual model, teachers are the least favourable towards the assumptions of the social model of this level of disability.

Analysis of the t-Student test results shows that the intensity of preference of a given model, for each group of respondents, is affected by the diversifying variable *level of disability* (Table **2**). Significantly stronger

Table 1:   **Respondents' Beliefs about Mild and Severe Intellectual Disability – Differences between the Groups, ANOVA (A – Students; B – Special Needs Teachers; C – Teachers)**

Subscales	M			F test result	LSD test result	
	A	**B**	**C**		**compared groups**	**p**
Individual model mild disability	12.09	11.26	12.47	*	B-C	**
Social model mild disability	22.30	24.38	22.35	***	A-B B-C	** *
Individual model severe disability	15.41	16.81	16.48	*	A-B B-C	*** ***
Social model severe disability	21.51	22.14	20.63	*	B-C	**

M: mean value; SD: standard deviations; F: Fisher-Snedecor test; p: level of significance; LSD test (Least Significant Difference test): post-hoc comparisons.
*$p < .05$; **$p < .01$; *** $p < .001$.

Table 2:   **Respondents' Beliefs about Mild and Severe Intellectual Disability – Differences Between the Levels of Disability, t-Student Test (A – Students; B – Special Needs Teachers; C – Teachers)**

Groups	M		SD		t	p
	Individual model					
	Mild disability	**Severe disability**	**Mild disability**	**Severe disability**		
A	12.09	15.41	3.59	4.33	-3.31	***
B	11.26	16.81	4.04	4.08	-5.55	***
C	12.47	16.48	4.01	4.37	-4.01	***
	Social model					
Groups	**Mild disability**	**Severe disability**	**Mild disability**	**Severe disability**	**Mild disability**	
A	22.30	21.51	4.37	4.32	.80	***
B	24.38	22.14	3.86	4.05	2.24	***
C	22.35	20.63	4.38	4.28	1.73	***

t – scores on the t-Student test; M – mean; SD – standard deviation.
*** $p < .001$.

preferences of the individual model were found in the case of severe disability, while significantly stronger preferences of the social model, in the case of mild intellectual disability. These tendencies were found in all groups of respondents.

DISCUSSION

The analysis was used to address complex research problems and hypotheses. It was found that the respondents' (students', special needs teachers' and teachers') beliefs are more strongly set in the social model of disability. It concerns both mild and severe disability. It should be noted, however, that the strength of agreement with beliefs characteristic of the

social or individual model is diversified in all groups of respondents. It was found that the strongest beliefs within the social model of mild and severe intellectual disability are displayed by special needs teachers, the weakest, by students (for mild intellectual disability) and teachers (for severe intellectual disability). The individual model is most strongly approved of by teachers, but only if it concerns mild intellectual disability. In the case of severe disability, special needs teachers agreed more strongly with statements characteristic of the individual model. It should be stressed that with the discovered preference of the social model by all the groups, the highlighted diversifying tendencies are noticeable in the strength of beliefs (weaker or stronger approval, and weaker or

stronger rejection), and not in their nature. The revealed tendencies corroborate the hypotheses concerning the diversification of preferences for models of mild and severe intellectual disability depending on the group. The greatest similarity between beliefs was noted in students and teachers. The hypothesis that diversification of models depends on the level of intellectual disability was corroborated. Possible reasons for the differences may be found in the statements included in both models. Certain ambivalence of respondents' beliefs becomes visible especially in the case of special needs teachers. A detailed analysis of the statements suggests that this ambivalence results, inter alia, from accepting certain assumptions (describing way, form of life and the nature of support of individuals with intellectual disability), and at the same time holding negative beliefs about the possibilities of implementing them. Respondents do not decidedly reject the statements which touch upon limitations of individuals with intellectual disability, related to, among other things, the possibility to self-determine, cooperate in the process of support, enjoy civil rights, and fulfil civic duties.

All in all, it is positive to see that the respondents strongly agree with the assumptions of the social model which expresses the need for an egalitarian and environmental model of life. Acknowledging these assumptions is essential for realizing the ideas of normalization and integration of individuals with intellectual disability. It is hard to unambiguously evaluate respondents' agreement with statements describing limitations of individuals with intellectual disability, since it is not known which causes of disability are suggested by the respondents – the individual or the social ones (as a result of inadequacy of certain solutions for support, or the presence of barriers). Taking into account the fact that respondents do not decidedly reject biological determinism in the aetiology of this disability, or the assumption about the dominance of medical procedures, it may be assumed that the aforementioned limitations are connected mainly with how individuals with disability function, with their deficits in cognitive, physical and mental processes.

Analysis to date devoted to teachers' and students' attitudes towards individuals with intellectual disability (or to ways of understanding this disability) offer quite pessimistic conclusions: they point to inadequate and stereotypical knowledge, tendencies towards biologization of the phenomenon with emphasis on

deficits, and unwillingness to make contact [13-16]. Comparative analyses with a control group of members of the general public and teachers imply that the latter have broader knowledge only of some issues, while their evaluation of possibilities for individuals with intellectual disability to function in various spheres of life is pessimistic and similar in its nature to the one expressed by respondents from the general public. What is also similar is the nature of accepting stereotypes related to personality traits of individuals with disability [17]. In explorations which compared respondents from the general public with teachers from special needs schools, results were significantly more favourable for teachers. It was visible in stronger pro-integration attitudes, smaller distance, stronger support for rights of individuals with intellectual disability and support for their autonomy [18]. Other studies reveal that teachers from special needs schools show more favourable attitudes towards individuals with intellectual disability (cognitive aspect and full attitudes i.e. including the cognitive, emotional and behavioural aspects) than teachers from mainstream schools [19-21]. These findings are generally convergent with the established tendencies. Special needs teachers agree with the assumptions of the social model of disability most strongly, and with the individual model, most weakly; yet this tendency concerns only mild intellectual disability. Results concerning evaluation of severe disability are not so homogenous. Special needs teachers function in segregated environments, acquire certain experiences in direct contact with individuals with intellectual disability, members of these individuals' closest environment, and other specialists who realize given forms of support (e.g. doctors or psychologists). These experiences can be positive or negative. Special needs teachers, of all the groups of respondents, have the best possibility to confront what they know (e.g. what they learnt at university) with real life situations. Since they function professionally in environments dedicated to supporting individuals with disability, they may develop greater awareness of certain postulates concerning optimal actions which may be undertaken to help them (e.g. reaching the environmental model of life, egalitarianism). Nevertheless, their assessment of the potential and limitations stemming from disability is not objective. This assessment, and therefore also the way of interpreting intellectual disability, is influenced by personal successes and failures experienced while working with these individuals (and persons from their closest environment). Presumably, work with individuals with severe disability is fraught with more

obstacles on the way to realize professional goals successfully, which makes professionals assess life possibilities of their clients more pessimistically.

CONCLUSION

The nowadays postulated understanding of intellectual disability, seen as a multidimensional state of human functioning is grounded in a broader concept of disability explicated in the International Classification of Functioning, Disability and Health (WHO). It is claimed that this Classification is a successful attempt at joining significant elements of the individual and social dimensions of disability [4]. Assumptions of this model, also known as the interactive model, postulate specific implications for ways of understanding and approaching intellectual disability. Its nature lies in interactions of biological and social factors which take place at all stages of an individual's life, influencing both aetiology of the phenomenon, and the development of the individual with disability [22, 23]. Individual elements in this model of disability include not only limitations and the potential which results from the aforementioned interactions, but also personal awareness, an ability to overcome limitations and barriers and developing one's own resources. Social elements (in close interaction with the individual ones) comprise personal factors (in the form of attitudes, accepted values and norms) and financial-organizational factors. The nature of professional duties, which lie with teachers (but not only) who work in special needs schools and mainstream schools, should be discussed in this context, including the perspectives of personal experiences and social conditioning. Their actions which reflect specific professional responsibilities should aim at creating the desired living conditions (in their financial and social dimension) for individuals with intellectual disability, and, what is related to the former, at developing life skills in individuals with this type of disability (inter alia: self-determination, autonomy, self-advocacy). As a result of these complex activities, individuals with intellectual disability should experience normalization of life, and enjoy mental and financial wellbeing [see 22]. Specialists' professional training must include developing attitudes towards individuals with intellectual disability so as to eradicate the condescending and paternalistic attitudes, which result in neglecting subjectivity in relationships of support, emphasizing the advantageous position of the specialist in decision making and responsibility for the final shape of the processes of education, rehabilitation and support. Instead, such attitude towards disability

should be developed that, irrespectively of the level of disability, the individual with disability will be the subject participating and taking decisions, able to express their needs and decide, at least to some extent, about the ways and means of fulfilling them. This is also connected to rejecting the negative perspective on intellectual disability, which presupposes difficulties and limitations connecting them to deficits in the physical and psycho-social spheres.

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