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The Importance of Positive Diagnosis in Work with Disabled People – Theoretical Reflection from a Psychopedagogical Perspective

Znaczenie diagnozy pozytywnej w pracy z osobą z niepełnosprawnością – refleksja z perspektywy psychopedagogicznej

Keywords:
salutogenesis, positive diagnosis, disability, diagnosis models, helping models

Summary: In the article, the author presents the basic assumptions of positive diagnosis that can be used in work with the disabled. It assumes that one of the most important factors determining the effectiveness of the development support process is a correctly implemented diagnostic process, immanently linked to helping disabled people integrate into the social world and overcome developmental problems resulting from their disability.

In the positive approach to diagnosis proposed by the author, various categories of the diagnostic description of a person and their environment are important, such as multidimensionality (various spheres of functioning), continuity (development process in the full life cycle), orientation of individual development (prosocial, pro-development vs. developmentally destructive), and, above all, the need to discover one's resources (potentials).

The author also presents the process and models of supporting the development of people with disabilities.

This approach locates the processes of diagnosis and help in the basic paradigm of positive psychology (salutogenesis), focusing on the self-creation and social integration of individuals with disability, while at the same time, stressing the need to identify the potential of the individual (positive diagnosis).

Słowa kluczowe:
salutogeneza,
diagnoza pozytywna,
niepełnosprawność,
modele diagnozy,
modele pomagania

Streszczenie: Autorka prezentuje w artykule podstawowe założenia diagnozy pozytywnej, możliwej do wykorzystania w pracy z osobami niepełnosprawnymi. Wychodzi z założenia, że jednym z najważniejszych czynników warunkujących efektywność procesu wspierania rozwoju jest prawidłowo realizowany proces diagnostyczny, immanentnie powiązany z procesem pomagania osobom niepełnosprawnym w integrowaniu się ze światem społecznym i w pokonywaniu problemów rozwojowych wynikających z ich niepełnosprawności.

W proponowanym przez autorkę pozytywnym podejściu do diagnozy istotne są różne kategorie opisu diagnostycznego człowieka i świata jego życia: wielowymiarowość (różne sfery funkcjonowania i obszary), ciągłość (proces rozwoju w pełnym cyklu życia), ukierunkowanie rozwoju jednostki (prospołeczny, prorozwojowy *vs.* destrukcyjny rozwojowo), a także przede wszystkim konieczność odkrywania jego zasobów (potencjałów). Autorka prezentuje również proces i modele wsparcia rozwoju osób z niepełnosprawnością.

Ujęcie to lokuje procesy diagnozy i pomocy w podstawowym dla poznania człowieka paradygmacie psychologii pozytywnej (salutogeneza), skoncentrowanej na autokreacji i społecznej integracji jednostki z niepełnosprawnością, co jednocześnie wyznacza konieczność identyfikacji specyficznych potencjałów jednostki (diagnoza pozytywna).

– let me o Lord… understand different people
different languages different sufferings
Zbigniew Herbert, *The Prayer of Mr. Cogito – Traveller*

Introduction

The disabled are exposed and used to evoke emotions whose beneficiaries are the non-disabled. They become objects of inspiration, just as porn actors are objects of desire – in both cases it is the viewers who are endowed with subjectivity.
(Zdrodowska, 2016, p. 397)

The story of disability can be divided into three basic narratives: a) *narratives of restitution* – which contain threads relating to one's struggle to return to previous health; b) *narratives of chaos* – regarding feelings of unhappiness and the conviction that life will never be better; and c) *narratives of quest* – focusing on the need to use one's own experience to help others (Frank, 1995, p. 103) as well as oneself. The initial premise of this study is that there is a need for positive diagnosis (of resources and potentials) referring to the third type of the narrative, in work with people "affected" by disability (regardless of its type). This appears to be of fundamental importance for building a world conducive to the development of all people, i.e., one that is integrated and appreciative of an individual as a person, regardless of the traditionally determined divisions into people who are "better" (without developmental deficits) and "worse" (with developmental deficits).

Both in science and in Polish educational reality, the concept of integration has different dimensions, including those related to belief and the behavior system. On the one hand, therefore, the focus is on building a formal educational system integrating everyone, regardless of their manifested deficits. On the other hand, and possibly more importantly, as it is a prerequisite for the success of the first factor, it aims to build a system of beliefs about others which would encourage tolerance for differences and the appreciation of resources and potentials of other people, even if they are unapparent. These beliefs are undoubtedly the basis for the formation of interpersonal relationships which, in turn, are inherently related to intrapersonal (self-perception and action in accordance with the image of the "I") and interpersonal (perception of others and action in accordance with the image of "I-others") competence. The field of positive diagnosis and the resulting activities supporting the development of

people with disabilities are related to a perception of the world which allows for the possibility of equal opportunity, as well as to the competences determining this possibility. As such, it is fundamental for the effective implementation of the idea of integration.

It is a truism to say that the effectiveness of inclusive education depends on a child's earliest experiences, and hence, that it should start in kindergarten (or possibly even earlier, in the family context). This idea has been reflected in the dynamic activity of the movement for building a joint education system for people with and without disabilities, which started about three decades ago. As a premise for creating inclusive education, the movement has adopted the need to create positive learning experiences as early as possible, which are the basis for shaping beliefs about oneself and the world, and thus condition the development of positive relationships between people with and without disabilities (i.e., learning each other). Shaping positive relations between people who are "different" is not an easy and spontaneous process, but one that requires work and the creation of a support system in the form of properly organized educational interactions. This first happens in the family environment, but the process is often hindered by the common stereotypes of people with disabilities. Later, it takes place at all levels of school education, which often requires the restructuring of the beliefs built earlier in the family and the beliefs of teachers themselves (Chrzanowska, 2019). We must also be aware of the fact that the source of exclusion for people with disabilities is not simply their physical, sensory, and mental deficits, but, above all, the organization of a society which is oppressive to them. As a category of exclusion, disability is socially constructed (Niedbalski, 2019, pp. 7–8); its deconstruction leading to integration must, therefore, also have a social character. In addition, it seems that the restructuring of the support system for people with disabilities should be of a deeper nature, especially in regard to people with more advanced and naturally limiting dysfunctions. An example of an effective integration system is the activities of the "Bethel" Bodelschwing Plant in Bielefeld in Germany (Wysocka & Baron-Borys, 1995).

One of the most important areas of this difficult educational work is shaping the social competences of both groups which, though different in certain areas, undoubtedly have a lot to offer to each other (Smogorzewska, 2019; Smogorzewska & Szumski, 2015). This, however, needs to be discovered through positive experiences in mutual relations which must be included in the development process of each person as early as possible. There is no other way to eliminate

the stereotypes that constitute a barrier between the world of non-disabled and disabled people. There is also no denying that the barrier between these two worlds is not only dependent on the negative beliefs of non-disabled people about integration, but also on the negative beliefs of people with disabilities about functioning in a world dominated by the "normals," and therefore, on their beliefs about themselves, other people and their relationships, the world, and their own lives.[1]

As I have already mentioned, the process of shaping mutual relations must be supported by appropriate educational interactions directed at shaping positive beliefs about people different from us ("each of us has something to give to others"). More and more often in the pedagogical literature, we talk about the importance of building the theory of mind (Putko, 2008; Smogorzewska, 2019). This theory refers to knowledge that helps one to understand and rationally explain the behavior of other people and ourselves, its role in shaping social competences, the quality of interpersonal relations and, generally speaking, the development of an individual in all spheres, i.e., the process of "becoming" independent of natural limitations that are in each of us ("after all, each of us is disabled in some way and degree"). In constructing models of the diagnostic process and post-diagnostic activities, special pedagogy still draws excessively from approaches specific to clinical psychology. That is why the so-called pathogenetic approach – focused on finding the causes, factors, mechanisms and conditions of disorders of the functioning of the individual in various spheres – predominates.

It seems that it is high time we changed or complemented this perspective. The normalization of the disabled is a necessity, and it cannot be done without learning about each other, i.e., restructuring the beliefs of both hitherto "opposite groups" (people with and without disabilities) about the following factors: (1) the need for and (2) the possibility of joint actions in the world, and (3) the benefits that both groups derive from being together. Beliefs, however,

[1] Research indicates (e.g. Wysocka, 2005; 2006; 2008a; 2008b; 2008c) that the developmental consequences and beliefs of people with disabilities about functioning in a world dominated by "the fully abled" are not positive: these people (children and adolescents) feel much better in special schools because they do not differ "negatively" from others (their self-esteem increases, which means that they develop better). Therefore, people with disabilities can take secondary and defensive negative attitudes towards people without disabilities, which are a source of their frustration in the process of building positive beliefs about themselves. A vicious circle of "misunderstandings" (stereotypical beliefs), intolerance and discrimination, operating on the basis of self-fulfilling prophecy, is a considerable barrier to the idea of integration.

should be built or changed as early as possible, because the normalization of mutual relations is then less burdened with already encoded and socially inherited stereotypes blocking these relations. Children's plasticity of mind and spontaneity in relationships guarantees this.

Special pedagogy and the dominant model of clinical diagnosis

I won't say hello to you in the street.
(Reimann, 2019)

Diagnostics, as a discipline which deals with the methods of data collection and analysis, is a set of directives that allow for an accurate and reliable assessment of phenomena of interest for a given scientific discipline. This assessment includes the state, structure, development, severity, regulating mechanisms and factors determining the formation and development of phenomena of interest for a given field. In different disciplines, therefore, its subject is formulated differently. However, one should bear in mind that regardless of the subject of the cognition process, it is always possible to objectively assess potentials and resources (positive diagnosis), as well as development deficits and barriers (negative diagnosis). Since the development of diagnostics and the high quality of diagnoses are both necessary conditions for the effectiveness of pedagogical activities (praxeology), it is worth realizing that this is only possible when one takes into account the full diagnosis (positive and negative). In fact, the priority of positive diagnosis should be assumed with regard to the design of post-diagnostic measures and their effectiveness.

It is generally known that pedagogical diagnostics itself develops within the methodology of pedagogical sciences and pedagogy as a general scientific discipline. Within the latter, the following categories are formally distinguished: axiology with teleology (upbringing goals: *What to achieve*), upbringing theory (theoretical and empirical determinants of actions: *How to achieve the assumed goals*), research (diagnostic and design, determining the relationship between the goals of upbringing and events leading to it: *What and how to learn*) and the methodology of upbringing interactions (principles, rules, directives of actions leading to assumed goals: *How to act effectively*) (Górski, 1993; Pytka, 2005; Wysocka, 2013). Diagnosis as a scientific discipline, therefore, draws on both pedagogical theories (and theories of related sciences) and the methodology of social sciences, and must also refer to the

principles of praxeology. Undoubtedly, this is a factor that determines both the subject and the methods of cognition used. In the context of the subject of cognition, and due to the fact that in special pedagogy we mainly deal with the "theory of deficits," this (wrongly) limits this subject to the assessment of negative states, i.e., to diagnoses of (clinical) disorders.

Special diagnostics, or diagnostics of deviations from the norm, is, therefore, a scientific field dealing with ways of recognizing individual states of affairs, their developmental tendencies – including deviations from the norm, disorders, diseases, and disabilities – which is based on the identification of their characteristic features or symptoms (Kostrzewski, 1993; Wysocka, 2013). This definition, evidently, has a clearly clinical (pathogenetic) character. In traditional terms, special diagnostics is an important part of special pedagogy that deals with the education of individuals that deviate from the norm and manifest a variety of developmental disorders associated with disability resulting from organic diseases and disorders, and determined by adverse psychological, social and educational factors. However, it focuses mainly on deficits and development barriers (negative diagnosis). Defining the principles of special diagnosis is further complicated by the fact that the subject of interest is a heterogeneous group of people with very diverse dysfunctions. This diversity conditions different educational needs associated with the specific developmental consequences resulting from various disorders. What unites this heterogeneous group, however, is that they cannot reach the level of development and adaptation to the implementation of social tasks and the requirements of professional roles within their potential capabilities without special external help (Maciarz, 2005). This assistance must be adequate to their special needs but, at the same time and perhaps above all, to their specific capabilities and resources. This is undoubtedly a premise for making a positive diagnosis (of potentials and resources) which not only complements the negative diagnosis (of deficits and limitations which may have different intensities in different conditions), but its results are treated as basic in designing post-diagnostic activities supporting the development of people with disabilities.

Special pedagogy, still treated much too often as the pedagogy of "handicapped individuals" who deviate from the norm in various areas and spheres (Lipkowski, 1993) – which excludes them from the fullness of social life (integration barrier) – focuses mainly on the clinical picture of disorders (negative diagnosis) and proposes as a dominant support system the elimination of these disorders (mainly through semiotropic and sometimes etiotropic activities

[when possible] because they relate to the complex and multiple secondary consequences resulting from primary deficits, often impossible to eliminate and subject to only partial compensation). Negative diagnosis requires the definition of the "norm," which applies not exclusively, but particularly, to special pedagogy. This, in turn, is associated with the adoption of a healthy human model and specifying the ideal state of an individual's functioning in all regulatory processes (orientation-cognitive, intellectual, emotional, motivational, control and executive – clinical diagnostics) as well as determining the extent of their disorders (partial vs. global). Another complication in special diagnosis is the fact that the genesis of disorders is often complex (polyethiology; genetic diagnosis), and the developmental consequences are multiple (diagnoses of significance). In terms of pedagogy, the latter are associated with the functioning of an individual with disability in various social roles – in school, family, peer relations, and generally in society, as well as meeting the requirements and expectations formulated by this society. This, in turn, is directly related to the integration process, and thus the full inclusion of individuals with disabilities into social life, which is, however, built on a specific "equal but not equal" basis.

Health and disease model – good life model and risk model versus special pedagogy

The mission of the humanities is to multiply stories
about human experience and interpret them in different ways.
(Markowski, 2013, p. 66)

The main questions that have been posed so far in special pedagogy have concerned the causes or factors determining disorders in the functioning of individuals with disabilities. The pathogenetic approach focuses on various causes and circumstances of the formation of disorders, explaining the relationship between a given pathogenetic factor and the process of defective psychosocial functioning, which determines the effectiveness of corrective actions based on the elimination of negative factors triggering the appearance of secondary disorders associated with disability. As is generally known, in psychopathology and psychiatry pathogenic factors are divided into three types: a) *psychogenic* (related to learning disabilities, disorders of regulation processes, personality structure development, bond development, socialization conditions, difficult stressful

situations or trauma-inducing situations); b) *somatogenic* (related to factors determining somatic diseases [e.g. infectious, toxic, and metabolic ones] and their correlates causing disorders of the nervous system); and c) *endogenic* (associated with genetic predispositions and constitutional properties of the individual, e.g., temperament, features of the nervous system and other body systems).

In psychology and special pedagogy, pathogenetic factors are traditionally most often divided into: a) *biological* (including genetic, constitutional and personality factors); b) *psychological* (including mainly personality, but also situational factors); c) *socio-cultural* factors related to the pathology of the living environment (Sęk, 2012, p. 40). We also know that these factors do not work in isolation; disorders in psychosocial functioning, in fact, are the result of the interaction of many of these determinants, always specifically related to each other, and thus creating a specific sequence and combination of factors for each individual (the *bio-psycho-social* model). This means that disorders of psychosocial functioning are multidimensional and dynamic phenomena derived from the interaction of many interrelated factors, both direct (primary, dominant and causative factors) and indirect ones (secondary factors and intermediary variables "strengthening" the disorder). Together, they constitute and determine the specificity of the disorder mechanism, which is why the purpose of diagnosis is to answer the question of how these mechanisms interact with each other, causing a disorder. The principle of the interaction of pathogenetic factors which undergo dynamic transformations in ontogenesis is at work here, creating overlapping layers of the pathogenetic process. **Layer I** is a permanent, hereditary and constitutional basis on which the predisposing factors (i.e., risk factors for pathology) act, but their existence does not have to determine the occurrence of the disorder; **layer II** includes etiopathogenic factors that disturb or damage the functioning of the central nervous system, not necessarily of a biological nature, e.g., conflicts, motives, or developmentally destructive beliefs; **layer III** embraces overlapping features of psychopathological syndromes (content, quality of disorders), as well as factors triggering disorders (see Sęk, 2012, pp. 41–42).

The interactive **susceptibility-stress model**, integrating various factors important in the genesis of disorders (Carson, Butcher & Mineka, 2003; Seligman, Walker & Rosenhan, 2003) combines the assumptions of the pathogenetic (risk, disease) and indirectly salutogenetic (good life, health) models. Indicated susceptibility (to disorders) is an alternative to the factors described in the concept of resilience (treated as non-susceptibility), seen as protective factors

conditioning good functioning (development and adaptation) in the world, despite the presence of adverse developmental factors (e.g., disability).

Susceptibility to disorders is determined by the predisposition of the individual (e.g., disability), which is the result of the interaction of related biological, psychological and socio-cultural factors which have different meanings in individual cases. These factors are treated as predisposing to disorders (susceptibility to secondary disorders resulting from basic dysfunctions), but they are not their direct cause (they do not trigger disorders or do not have causative power). In the susceptibility-stress model, the causative factor is the primary stressor (an aggravating factor), the so-called pathogen, i.e., difficult situations and everyday adversities or critical life events (experienced trauma), which may result from experiencing disability. However, it does not have independent "causative power" either, i.e., it is not a single factor causing disorders in psychosocial functioning. Only the interaction of both factors, susceptibility primarily associated with, e.g., disability (polyethiologically – bio-psycho-socially and culturally conditioned) and the experienced difficult situations treated as derivatives of disability, trigger the disclosure of secondary developmental disorders (in psychosocial functioning of individuals with disabilities). The effects of chronic stress, treated as a result of one's failure to meet specific life requirements (self-fulfillment) due to disability, is co-determined by, e.g., the state of the nervous system (strength and reactivity) and the physical state of the body. At the same time, however, attention is drawn to the possibility of various protective mechanisms that increase stress resistance (immune resources) developed, for instance, in the concept of resilience or one of coherence (which is discussed further on). This concept is exemplified by the model of cross-disorder risk syndromes, the so-called risk-factors model, exposing the importance of various overlapping biological, personality, temperamental and behavioral risk factors and life stresses, which are correlates of disorders with different strengths, and hence with different probabilities of causing disorders. It can be assumed that the more such factors appear in the life of an individual with a disability, the greater the risk of disorders in their psychosocial functioning. The cross-disorder model allows one to build complex systems of explanatory factors with different causative power, while indicating important mechanisms and the course of the disorder development process. Generally speaking, these types of concepts assume that particular predispositions of the individual (e.g., disability) and patterns of reacting to difficult, stressful situations derived from the experienced disability

formed in the process of socialization and acquisition of life experiences, create an "individual program" of the individual's functioning. This "program" stands in contradiction with the requirements of life, leading to disorders which join in the process of strengthening one another (Levi, 1974; Sęk, 2012, pp. 43–44).

It should be noted, however, that these concepts also indicate (although such analysis is usually omitted) the existence and importance of protective factors that block the dynamics of the pathogenetic process. In addition to risk factors and so-called susceptibility to stress, the individual also has various protective mechanisms at their disposal that increase the individual's resistance to stress. This allows for the combining of both approaches to the etiology of disorders (the pathogenetic and the salutogenetic one) (Sęk, 2012, p. 43) and for creating complementary models, with strong emphasis on the importance of the positive approach, i.e., salutogenesis.

The salutogenesis model proposed by Aaron Antonovsky (1979; 1987; 1997; 2005) breaks the paradigm of the negative approach in the sciences of health and disorders. He refers to the transactional theory of stress by Richard Lazarus (1966; Lazarus & Folkman, 1984), but he significantly reinterprets it and broadens its assumptions. Antonovsky assumes that the natural state of an individual's functioning is a dynamic state of equilibrium, because the individual and their body are a system subject to the laws of entropy (the system's tendency to disorganize) and negentropy (the system's ability to organize). An individual constantly encounters stressful stimuli that are various and ubiquitous in their life, or – as is the case of people with disabilities – experiences various limitations resulting from them. They react to these stimuli and must tune in to them, wanting to maintain a dynamic balance of their own life processes at a specific level, optimal for their own functioning. Therefore, maintaining a state of health is a process of constant responding to requirements arising from the environment and from within the individual himself/herself in order to restore or maintain a certain level of organization of its functioning (the level of dynamic internal and external balance of the system). For people with disabilities, this process is much more difficult but possible with appropriate support from the environment. Health is treated here as a continuum rather than a dichotomous process (health, proper functioning vs. illness, pathology). A continuum approach to the process of disorders is also important for the diagnosis of deviations from the norm, allowing one to determine the level of threat of disorders or of disorders themselves (diagnosis of the condition and

consistent diagnosis – meaning) and their phase (phase diagnosis). Assessment of the level of health (positive approach) is possible, taking into account both of the two criteria and, at the same time, the perspectives for assessing the various properties of the individual (and indirectly, the world in which the individual lives): a) objective, from the perspective of the observer (diagnostician) and b) subjective, from the perspective of the actor (individual).

What is very important in Antonovsky's concept, also for special diagnostics, is an attempt to determine health (protective) factors, allowing one to capture the sources of the occurrence of specific disorders, factors of individual development and, at the same time, conditions of recovery (dynamic system balance). It is worth pointing out the most significant factors distinguished by Antonovsky, namely: (a) generalized resistance resources (GRR), which can be associated with the resources described in the concept of resilience; (b) stressors that can be of different nature (disability and its consequences); (c) sense of coherence (SOC), which is fundamental to this concept; (d) behavior, i.e., the individual's lifestyle. These factors are interrelated, constituting a set of dynamically acting and interacting health factors (or lack thereof).

What is important for the model of special diagnosis is that Antonovsky's concept assumes the natural complementarity of the pathogenetic and salutogenetic model (health and disease as a continuum); therefore, both approaches should be developed interactively, as these models complement each other. The pathogenetic model is used when we want to explain the causes of developmental problems, and focuses on susceptibility factors, stressors and pathogens, as well as all external factors that predispose and trigger pathological conditions. In general, we try to identify and explain the pathomechanisms of disorders. We use the salutogenetic model, on the other hand, when we identify and explain health behavior and proper development despite dysfunctions (e.g., disability); we focus on factors conducive to development, protecting one against disorders and launching dynamic processes for proper functioning. Therefore, we tend to look for the immune resources of the individual, but also of their life environment at all levels: biological, psychological and socio-cultural.

For Antonovsky, it is the sense of coherence (meaningfulness, comprehensibility and resourcefulness) that is the most important for the health and proper psychosocial development of an individual. In the cognitive approach, this is included in the field of forming beliefs about oneself, the world and one's relations with the world, and about the possibility of effective action in it. These properties develop only when the world is perceived as friendly, hospitable

and not exclusive or discriminatory due to "difference" (an integration model that accepts and appreciates differences).

However, the basic problem, it seems, is the process of integrating a common model of thinking about the determinants of well-being, i.e., obtaining a proper internal and external balance (integrating mechanisms of salutogenesis and pathogenesis of behavior). What makes this problem even more crucial is that the process of health and the proper development of an individual is presented as a continuum in which – apart from clearly described marginal poles (deficits – resources) – there are many intermediate states that can be determined by various factors. We are still insufficiently dealing with this differentiation in the diagnosis process. One of the solutions in this area can be, as Helena Sęk (2012, pp. 52–53) claims, adding to the salutogenesis model elements of analysis appropriate for the model mentioned above: susceptibility – stress. This means that stress factors should be analyzed in the context of susceptibility (risk factors, negative model, pathogenesis) vs. resistance (protective factors, e.g., resilience, positive model, salutogenesis). Human development is then recognized in pathogenetic and salutogenetic categories simultaneously, i.e., complementarily, which is undoubtedly possible at the level of health and disease diagnosis.

However, the problem of what supportive actions to take in order to first uncover and then activate an individual's potential and resources (automatically compensating – though not always comprehensively – for their deficits) remains open. Disorders which result from experienced deficits (e.g., behavioral ones) cease to be functional when the individual's potential is discovered, allowing them to meet their needs in a manner consistent with the requirements of the environment and to develop ("become a full person") to the best of their abilities with the support of a friendly environment.

The proper development of the individual in accordance with this concept includes the formation of positive beliefs about their own functioning in the world and its determinants related to their perception of: a) oneself, other people and their relationships with them and the surrounding world; b) coping with the world (constructive vs. destructive), with a recognition of coping styles and supporting the process of shaping constructive styles of overcoming problems.

It is worth pointing out that in the model of dealing with problems or limitations, and particularly with the stress they cause, the most important factors include: the quality of life events (negative, e.g., stressors, deficits; positive,

e.g., successes); the method of their subjective assessment (as a challenge or threat, e.g., attitudes, beliefs about oneself, other people, relationships with other people, the world); personality type (vulnerable or resistant to threats, e.g., resilience; optimism – pessimism, sense of coherence); one's habitual way of responding to difficult situations shaped by personal life experiences (coping strategies – constructive, adaptive, destructive, disadaptive; lifestyle – healthy, anti-healthy); resources from the environment (physical, material, socio-cultural) – rich or poor in sources of support, i.e., strong or weak bonds, a sense of having or lacking support. These factors interact with each other in the context of their qualitative categories (types of resources) and their orientation (positive, negative), having specific significance in overcoming difficult situations (developmental problems, life events, deficit development conditions).

In the process of diagnosis, these factors can be recognized simultaneously, always creating an individual model of factors determining development as well as salutogenetic and pathogenetic tendencies. How one designs postdiagnostic supportive activities depends mainly on the adopted theoretical perspective; however, a generally accepted rule is that in building development support systems, priority should be given to actions related to potentials and resources (ergotropic activities) as they are more effective from the praxeological and psychological point of view. This is justified by the following arguments: (1) actions referring to potentials (positive diagnosis) eliminate resistance to change and the fear of risk of developmental activities (the elimination of primary deficits, e.g., a disability, is often impossible, and also indicates the individual's dysfunction, which for them is difficult psychologically); (2) actions based on potential strengthen the beliefs of the individual about their own positive values and capabilities, which translates into better functioning even in the disordered spheres. I have already emphasized that it is not without significance in the positive approach to link the actions with the diagnostic and therapeutic relationship, which is easier and better to develop when we perceive an individual with disabilities in positive categories and treat them as "non-deficit." This strengthens the conviction of the individual that it is possible for them to overcome problems and function as a rightful member of an integrated (non-exclusive) community.

There is no doubt that the diagnostic and postdiagnostic activities, as stages in the process of supporting the development of people with disabilities, must be implemented primarily in the positive approach – which can be analyzed in the context of models of health (the salutogenetic current) and disease

(the pathogenetic current) – yet using the principles of complementarity (with priority on the health model and the subordination of the disease model). It is worth noting that the problem of the complexity of diagnosis, related to the principle of combining positive and negative diagnosis (the need to identify the strengths and weaknesses of the individual and the conditions in which their development takes place), is very important from the perspective of the praxeology of development support activities. Without it, the effectiveness of planned modification activities is reduced. The basic principle of pedagogical activity is to prioritize an individual's strengths, i.e., to prioritize ergotropic activities (activating and strengthening the potential of the individual) based on identified resources and potentials. Activities directly eliminating the signs of dysfunctional behavior and living conditions, on the other hand, should be complementary, which is determined by the principle of "succession" of semiotropic activities (eliminating the symptoms of disorders) based on deficits and limitations. Activities aimed at eliminating the causative factors (primary and secondary), i.e., eliminating the causes of disorders, are also important here. This particularly applies to secondary disorders (e.g., negative self-image) resulting from primary limitations (disabilities) which are often impossible to overcome in the process of full compensation. This is determined by the principle of the importance of etiotropic activities and the diagnosis of the etiology of secondary disorders (Czapów, 1980).

This problem has been theoretically resolved; praxeological rules of corrective action say that the condition for their effectiveness is a comprehensive diagnosis (full diagnosis: both, positive and negative), not only in terms of the level and type of disorders in the functioning of the individual and the dysfunctionality of its development conditions (symptomatological – identification, causal and consequential diagnosis – negatively focused on disorders, associated with semiotropic and etiotropic activity), but also in terms of the proper functioning of the individual in their environment (diagnosis of potentials – identification – positively oriented and related to ergotropic activities). Therefore, postdiagnostic activities must include positive diagnosis, used indirectly in actions aimed at eliminating disorders (Tokarczyk, 1997), which was emphasized in Irena Obuchowska's model of developmental diagnosis by (1983; 1997).

In pedagogical practice (also in special pedagogy), a preliminary diagnosis (diagnosis of deviations from the norm) of a selective nature (the basis for qualifying for specific intervention measures) mainly contains conclusions

assessing the extent of an individual's deficits and possibly their developmental consequences, usually without any information about their development potential which, however, undoubtedly exists. This limits the scope of post-diagnostic design in the field of ergotropic activities and, moreover, causes problems in diagnostic and therapeutic contact (in its establishment and development), which is no less (and often more) important for the effectiveness of intervention measures. One should bear in mind that activities aimed solely at correcting deficits indicate difficulties in building the humanistic and psychological dimension of diagnostic and therapeutic contact. This problem does not exist (or is less visible) in actions supporting the development of discovered potentials, which improve the functioning of the individual in spheres originally disturbed as a result of experienced disability. This contact is then based on positive emotions, such as trust, directly convincing the individual with disabilities that others treat him/her as a "full-fledged person" with development opportunities (potentials). Moreover, it also helps one to build a positive self-image in a world which appears friendly and does not discredit anyone because of their limitations. The optimistic thesis, constituting the main premise of actions supporting the development of people with disabilities, is associated with the statement that although it is impossible to change some events in life (disability), one can change their own approach to them. This places the concept of salutogenesis directly in the cognitive trend. Restructuring beliefs about oneself and the world and the possibilities of one's own positive actions can improve mutual relations between the two worlds – of disabled and non-disabled people.

Help models vs. disability

By researching a specific life, I hope to understand the way of life in general.
(Ellis & Bochner, 2000, p. 737)

Treating the diagnostic process as directly related to design of postdiagnostic activities, it is worth referring to the models of assistance also used in work with people with disabilities. In psychology of help, for instance, there are two basic and four derivative models of development support, applicable in various life situations but characterized by a number of limitations. They fit into the risk (pathogenetic) or good life (salutogenetic) model but they also have peculiar significance for formulating the principles of positive diagnosis.

These are compensatory, moral, educational and medical models (Brammer, 1984; Brickmann et al., 1983a; Brickmann et al., 1983b) which fit into the "model of giving" what the individual is missing (educational, medical and partly moral model) or the "support model" in the process of self-achievement of goals (compensation model). The criteria for description, explanation (methodology of diagnosis) and postdiagnostic activity (methodology of supportive action) are different in these models.

The compensation model assumes low responsibility of the individual for the problem but high for its solution if they are provided with a certain type of support. Therefore, an individual requires a degree of power, possibilities and competences that must be initially provided for him or her. The psychological situation of the individual is favorable in this model because they realize the importance of their own experiences and understand their own situation, as well as the sources of their problems. In addition, the individual has a sense of subjectivity in the process of change, learns self-confidence and independence. This is the only beneficial model of development support, because it fulfills the condition of justified, fair (faultless disability) and effective (serving internal change and learning to cope) assistance. It also provides the individual with active control over their own lives and over the way they use help to overcome their problems. This model can be inscribed within the field of control (Tokarczyk, 1997, pp. 53–54), which assumes the need to provide the individual with the resources that they lack, so that the correct features and behaviors can be formed that would make them capable of functioning properly in the world. These resources can or should be used in learning to cope with life difficulties. In the context of special diagnosis (deviations from the norm), its subject is mainly the individual's potential which supports the process of change. Obviously, however, it is also necessary to refer in the diagnosis to the manifestations of disorders associated with environmental deficits, which allows for determining the mechanism of developmental problems experienced by the individual.

The moral model (usually used in resocialization) is associated with assigning high responsibility to an individual for both a problem and its solution. This means that the individual is credited with responsibility for the problem but, at the same time, is treated as resourceful and capable of solving it independently. It results from the subjective treatment of the individual who always has the opportunity to choose whom to become. The decision on the mode of action (pro-development vs. developmentally destructive) belongs to the

individual, too. Leon Tyszkiewicz (1997) indicates two important variables, "decisive self" and "decision-making ease," which complement various factors affecting the individual throughout their life.

This means that the individual has the ability to choose the ways to meet their inalienable needs, but they make their decision on how to act (constructively or destructively) based on important factors. Importantly, the nature of the decision and the decision-making ease depend on the overall life situation of the individual and their life experience. In the case of people with disabilities, this choice is relative, and the inhibitor is the oppressive attitude of society towards disability. Decision-making ease is present in every case, but its extent is different. Here, the individual needs motivation for constructive and pro-development action, triggered by a supportive society, striving for equality. This model, to some extent, can be used in special pedagogy, because by inducing the individual to assume full responsibility for their life and development, it shapes their control mechanisms and their sense of agency. Its weakness in the context of the needs of people with disabilities is the belief that an individual can and should (with moral responsibility) deal with all of their problems alone. This alienates the individual from the social environment, depriving them of the opportunity to receive support. What seems problematic here is the fact that the person is burdened with their own failures (guilt) and cannot count on someone else to help them solve their problems (they have to deal with them on their own). The subject of diagnosis and, at the same time, of postdiagnostic activities, is the motivation of the individual to develop and change the level of this motivation (low, high or lack thereof) and its type (internal, external, autotelic, instrumental). From the perspective of building a sense of agency and subjectivity in the development process, it is undoubtedly important to identify the personal potentials and resources available to the individual in their environment, which form the basis for a reflective, conscious and responsible process of change. The purpose of the supporting action is, therefore, for the individual to gain a sense of internal control over his fate and action, and the belief that they can shape themselves and their own lives (internal, autotelic motivation), which must precede or overcome any awareness that their deficiencies are "harmful" for them (i.e., that they block the possibility of revealing and developing their own potentials).

The medical model assumes low responsibility of the individual for the occurrence of their problems (disability) but, at the same time, no control over their solving (possibilities and ways of acting for development). It is a clinical

model, still dominant in special pedagogy, objectifying a person with a disability as helpless and permanently dependent, unable to cope alone with their own problems due to the disability they experience. The individual here is deprived of any influence on the changes that take place in their life and behavior and, at the same time, feels relieved of any responsibility for their fate (and development), because nothing depends on them. This model is undoubtedly not conducive to integration, because it strengthens the experience of difference and the individual's unequal treatment as a weaker person, incapable of independence; it shapes a sense of constant dependence on external help, which may entail either learned helplessness or the formation of an exploitative attitude. As a result, the functioning of the individual deteriorates even in previously undisturbed spheres (Popiołek, 1995, pp. 58–61). The activities designed in this model, therefore, lead to a feeling of helplessness and block autonomous development. The diagnosis is negative here, focusing on deficits that a person with a disability cannot overcome on their own due to their past and predicted future (always independent of them). The image of such an individual is very negative; they appear to require constant support because they have no available resources, and it is impossible to teach them how to be self-sufficient. The possibilities of a person with a disability to undergo internal transformation (development) in an autonomous manner are here discredited.

The educational model is described as one in which a person is highly responsible for the problems they experience, but they are not ascribed responsibility for solving them due to the perceived natural lack of competence in this area. This model promotes the formation of a negative self-image (as a weak, imperfect individual) and the creation of dependency attitudes, resulting in the lack of independence in solving one's own problems. It promotes a high degree of submission to social control due to the belief that it is impossible for an individual to cope with problems unaided. It is not difficult to notice that this model reflects the most negative way of thinking about the nature and process of becoming human. It assumes dispositionally conditioned responsibility for one's own situation (a person is guilty of who they have become), yet at the same time, relieves them of responsibility for the effort of their own transformation and deprives them of "power" (control) over their own fate (the person does not have resources that can be used in the process of change). Its use undoubtedly results in the loss of faith in one's own strength and increases guilt and humiliation that is all the more painful, because even the achieved developmental effects are solely the result of external influences. This model

is the closest to the risk model but it even further limits the means of action to eliminate the symptoms of the disorder. The diagnosis here is only clinical and its object is merely to identify the symptoms of disorders that are modified or eliminated in accordance with the adopted philosophy of action.

Assessing briefly the cited models of support in development, it seems evident that educational and medical models objectify almost completely the individual (no responsibility for solving their problems, learned helplessness), while the moral model deprives the individual of support available in the community. Undoubtedly, they do not serve the implementation of the idea of integrating a person with disability into society – the first two, because they foster a negative self-image and a sense of inferiority, the third, because of directly expressed ostracism. Ultimately, therefore, their results cannot be positive in the context of shaping one's sense of internal control over the development process (lack of subjectivity and sense of agency) and its orientation (development goals planned and achieved). The only model in which an individual is treated as a subject and, at the same time, is not deprived of the necessary support in the community is the compensatory model, which partly reflects the assumptions of the good life model (salutogenesis), while enabling the integration of a person with disability into their social environment on an "equal rights" basis.

Conclusion – the use of positive diagnosis in special education

> *Does the world need the weak and the disabled? And why would it?* […] *My disability is enough for me and somehow, I am not drawn to exploring this topic further. I prefer to run away from it in any way possible, e.g., into my perfect dream world, into sleep, into loneliness. I already feel redundant, and now this question.*
> (Żywicki, 2010, pp. 25–26)

The social categorizing of people with disabilities as weak and, therefore, absent from social life (Filińska, Momot & Wojciechowski, 2010) must change. Undoubtedly, the current situation of an individual with a disability reflects the situation of a weak (weaker) individual in modern civilization. However, one has to ask the question of whether it has to be this way, which is related to the question of whether the weak and the disabled may be needed by the world and why (Żywicki, 2010, pp. 25–29). This question can be considered unfair, immoral and unreasonable because it reflects directly the oppressive

and excluding attitude of society towards the weaker (?), simply because they are not fully able. Undoubtedly, adopting such a perspective, we must take decisive steps to try to look at disability in positive terms, diagnose potentials and use them in the process of supporting the development of people with disabilities. What is needed (and possible?), though undoubtedly difficult, is to change our beliefs about what disability is and what it can mean for us, our beliefs about the possibilities and potentials that are in every person, regardless of their deficits. It is necessary to focus on what people with different disabilities *can* do, not on what they *cannot* do. Many problems appear to us to be unsolvable, but the basic ones are related to understanding the world of people with disabilities, comprehending their specific situation and appreciating what they can offer us (positive diagnosis). Unfortunately, this is what Dariusz Żywicki (2010, pp. 26–27) wrote about the world where people with disabilities live today: "I would prefer to sit at home, although I often associate it with prison, with a life sentence, than to engage someone to help me to get out and overcome all the obstacles – architectural (and these are not limited to curbs), but also those in your head."

References

Antonovsky, A. (1979). *Health, Stress and Coping: New Perspectives on Mental and Physical Well-Being*. San Francisco: Jossey Bass.

Antonovsky, A. (1987). *Unraveling the Mystery of Health. How People Manage Stress and Stay Well*. San Francisco: Jossey Bass.

Antonovsky, A. (1997). Poczucie koherencji jako determinanta zdrowia [The Sense of Coherence as a Determinant of Health]. In: I. Heszen-Niejodek & H. Sęk (eds.), *Psychologia Zdrowia* [Health Psychology] (pp. 206–231). Warszawa: Wydawnictwo Naukowe PWN.

Antonovsky, A. (2005). *Rozwikłanie tajemnicy zdrowia. Jak radzić sobie ze stresem i nie zachorować* [*Unraveling the Mystery of Health. How People Manage Stress and Stay Well*]. Warszawa: Wydawnictwo Instytutu Psychiatrii i Neurologii.

Brammer, L.M. (1984). *Kontakty służące pomaganiu: procesy i umiejętności* [*Helping Contacts: Processes and Skills*]. Warszawa: Studium Pomocy Psychologicznej PTP.

Brickmann, Ph., Kidder, L., Coates, D., Rabinowitz, V.C., Cohn, E. & Karuza, J. (1983a). The Dilemmas of Helping. Making Aid Fair and Effective. In: J.D. Fisher, A. Nadler & B.M. DePaulo (eds.), *New Directions in Helping*, Vol. 1 (pp. 18–49). New York: Academic Press.

Brickmann, Ph., Rabinowitz, V.C., Karuza, J., Coates, D., Cohn, E. & Kidder, L. (1983b). Modele pomagania i radzenia sobie [Models of Helping and Coping]. *Nowiny Psychologiczne*, *5*, 1–27.

Carson, R.C., Butcher, J.N. & Mineka, S. (2003). *Psychologia zaburzeń. Człowiek we współczesnym świecie* [*Psychology of Disorders. A Person in the Modern World*], Vol. 1–2 transl. W. Dietrich et al. Gdańsk: Gdańskie Wydawnictwo Psychologiczne.

Chrzanowska, I. (2019). *Nauczyciele o szansach i barierach edukacji włączającej*. [Teachers Talk about Opportunities and Barriers to Inclusive Education]. Warszawa: Wydawnictwo Naukowe PWN.

Czapów, C. (1980) *Wychowanie resocjalizujące – elementy metodyki i diagnostyki* [*Resocialisation Education – Elements of Methodology and Diagnostics*]. Warszawa: Państwowe Wydawnictwo Naukowe.

Ellis, C. & Bochner, A.P., (2000). Autoethnography, Personal Narrative, and Reflexivity: Researcher as Subject. In: N.K. Dnezin & Y.S. Lincoln (eds.), *Handbook of Qualitative Research* (pp. 733–768). Thousand Oaks: Sage Publications.

Filińska, M.D., Momot, B. & Wojciechowski, A. (eds.). (2010). *Obecność i nieobecność. Sytuacja człowieka słabego we współczesnej cywilizacji (przyczynek do studium)*. [*Presence and Absence. The Situation of a Weak Individual in Modern Civilization (A Contribution to a Study)*]. Toruń: Wydawnictwo Naukowe Uniwersytetu Mikołaja Kopernika.

Frank, A.W. (1995). *The Wounded Storyteller*. Chicago: The University of Chicago Press.

Górski, S. (1993). Metodyka wychowania resocjalizującego [Methodology of Resocialisation Education]. In: W. Pomykało (ed.), *Encyklopedia pedagogiczna* [*Pedagogical Encyclopedia*] (pp. 367–372). Warszawa: Fundacja "Innowacja".

Kanfer, F.H. & Goldstein, A.P. (1985). Psychologiczne metody pomagania innym [Psychological Methods of Helping Others]. *Nowiny Psychologiczne*, *1*, 2–18.

Kostrzewski, J. (1993). Diagnoza odchyleń od normy [Diagnosis of Deviations from the Norm]. In: W. Pomykało (ed.), *Encyklopedia pedagogiczna* [*Pedagogical Encyclopedia*] (pp. 105–109). Warszawa: Fundacja "Innowacja".

Lazarus, R. (1966). *Psychological Stress and the Coping Process*. New York: Springer.

Lazarus, R. & Folkman, S. (1984). *Stress, Appraisal and Coping*. New York: Springer.

Levi, L. (1974). Psychosocial Stress and Disease: a Conceptual Model. In: E.K.E. Gunderson & R.H. Rahe (eds.), *Life Stress and Illness* (pp. 231–287). Springfield JU: C. Thomas.

Lipkowski, O. (1993). Pedagogika specjalna [Special Pedagogy]. In: W. Pomykało (ed.), *Encyklopedia pedagogiczna* [*Pedagogical Encyclopedia*] (pp. 572–576). Warszawa: Fundacja "Innowacja".

Maciarz, A. (2005). Pedagogika specjalna [Special Pedagogy]. In: T. Pilch (ed.), *Encyklopedia pedagogiczna XXI wieku* [*Pedagogical Encyclopedia of the 21st century*], Vol. 4 (pp. 262–264). Warszawa: Wydawnictwo Akademickie "Żak".

Markowski, M.P. (2013). *Polityka wrażliwości. Wprowadzenie do humanistyki* [*Sensitivity Policy. Introduction to Humanities*]. Kraków: Wydawnictwo Universitas.

Niedbalski, J. (2019). *Niepełnosprawność i osoby z niepełnosprawnością. Od pasywności i wykluczenia do aktywności życiowej i integracji społecznej* [*Disability and the Disabled. From Passivity and Exclusion to Life Activity and Social Integration*]. Łódź: Wydawnictwo Uniwersytetu Łódzkiego.

Obuchowska, I. (1983). *Dynamika nerwic. Psychologiczne aspekty zaburzeń nerwicowych u dzieci i młodzieży* [*The Dynamics of Neuroses. Psychological Aspects of Neurotic Disorders in Children and Adolescents*]. Warszawa: Państwowe Wydawnictwo Naukowe.

Obuchowska, I. (1997). Diagnoza psychologiczna w poradniach psychologiczno-pedagogicznych [Psychological Diagnosis in Psychological and Pedagogical Counseling Centers]. *Problemy Poradnictwa Psychologiczno-Pedagogicznego*, *2*(7), 5–15.

Popiołek, K. (1995). Modele pomagania i ich konsekwencje pedagogiczne [Models of Helping and their Pedagogical Consequences]. *Chowanna*, *1*(4), 57–63.

Putko, A. (2008). *Dziecięca "teoria umysłu" w fazie jawnej i utajonej a funkcje wykonawcze* [*Children's "Theory of Mind" in the Explicit and Latent Phase and Executive Functions*]. Poznań: Wydawnictwo Naukowe Uniwersytetu im. Adama Mickiewicza.

Pytka, L. (2005). Pedagogika resocjalizacyjna [Resocialization Pedagogics]. In: T. Pilch (ed.), *Encyklopedia pedagogiczna XXI wieku* [*Pedagogical Encyclopedia of the 21st Century*], Vol. 4 (pp. 249–251). Warszawa: Wydawnictwo Akademickie "Żak".

Reimann, M. (2019). *Nie przywitam się z państwem na ulicy. Szkic o doświadczeniu niepełnosprawności* [*I will not say hello to you in the street. A Sketch about the Experience of Disability*]. Wołowiec: Wydawnictwo Czarne.

Seligman, M.E.P., Walker, E.F. & Rosenhan, D.L. (2003). *Psychopatologia* [*Psychopathology*]. Poznań: Zysk i S-ka.

Sęk, H. (2012), Orientacja patogenetyczna i saulogenetyczna w psychologii klinicznej [Pathogenetic and Saulogenetic Orientation in Clinical Psychology]. In: H. Sęk (ed.), *Psychologia kliniczna* [*Clinical Psychology*], Vol. 1 (pp. 39–54). Warszawa: Wydawnictwo Naukowe PWN.

Smogorzewska, J. (2019). *Środowisko szkolne a rozwój teorii umysłu u dzieci w młodszym wieku szkolnym. Badanie podłużne uczniów z niepełnosprawnością i bez niepełnosprawności* [*The School Environment and the Development of Mind Theory in Younger School Age. Longitudinal Examination of Students with and without Disabilities*]. Warszawa: Wydawnictwo Naukowe PWN.

Smogorzewska, J. & Szumski, G. (2015). *Rozwijanie kompetencji społecznych dzieci przedszkolnych. Teoria – Metodyka – Efekty* [*Developing Social Competences of Pre-school Children. Theory – Methodology – Effects*]. Warszawa: Wydawnictwo Naukowe PWN.

Tokarczyk, E. (1997). Diagnoza dla celów resocjalizacji – specyfika i wynikające z niej trudności [Diagnosis for Resocialization Purposes – Specificity and Resulting Difficulties]. *Problemy Poradnictwa Psychologiczno-Pedagogicznego*, *2*(7), 52–54.

Tyszkiewicz, L. (1997). *Kryminogeneza w ujęciu kryminologii humanistycznej* [*Criminogenesis in terms of Humanistic Criminology*]. Katowice: Wydawnictwo Uniwersytetu Śląskiego.

Wysocka, E. (2005). Źródła i mechanizmy kształtowania się postaw wobec niepełnosprawnych – analiza teoretyczna i empiryczne egzemplifikacje [Sources and Mechanisms of Shaping Attitudes towards the Disabled – Theoretical Analysis and Empirical Exemplifications]. In: J. Rottermund & A. Klinik, in cooperation with S. Wrona (eds.), *Wybrane uwarunkowania rehabilitacji osób niepełnosprawnych* [*Selected Conditions for the Rehabilitation of the Disabled*] (pp. 195–214). Kraków: Oficyna Wydawnicza Impuls.

Wysocka, E. (2006). Zraniona tożsamość ludzi niepełnosprawnych – źródła, konsekwencje i radzenie sobie z wewnętrznym piętnem i zewnętrznym „napiętnowaniem" [Wounded Identity of People with Disabilities – Sources, Consequences and Dealing with Internal ande External 'Stigma']. In: J. Rottermund (ed.), *Wybrane aspekty pracy z niepełnosprawnymi* [*Selected Aspects of Working with the Disabled*] (pp. 173–190). Kraków: Oficyna Wydawnicza Impuls.

Wysocka, E. (2008a). Experiencing Life and Problem-Solving Strategies from the Perspective of Disabled Youth vs Disabled Adults. *The New Educational Review*, *1*(14), 29–43.

Wysocka, E. (2008b). Experiencing Life from the Perspective of Disabled Youth. In: T. Żółkowska & M. Wlazło (eds.), *Special Pedagogy within Theoretical and Practical Dimension* (pp. 539–548). Szczecin: Wydawnictwo Uniwersytetu Szczecińskiego.

Wysocka, E. (2008c). Strategie radzenia sobie i konsekwencje radzenia sobie z doświadczanymi problemami w deklaracjach młodzieży niepełnosprawnej [Coping Strategies and Consequences of Coping with Problems in Declarations by Disabled Youth]. In: T. Żółkowska & M. Wlazło (eds.), *Pedagogika społeczna – koncepcje i rzeczywistość. Socjopedagogiczne aspekty rehabilitacji osób niepełnosprawnych* [*Social Pedagogy – Concepts and Reality. Socio-pedagogical Aspects of Rehabilitation of the Disabled*] (pp. 301–308). Szczecin: Wydawnictwo Uniwersytetu Szczecińskiego.

Wysocka, E. (2013). *Diagnostyka pedagogiczna. Nowe obszary i rozwiązania* [*Pedagogical Diagnostics. New Areas and Solutions*]. Kraków: Oficyna Wydawnicza Impuls.

Wysocka, E. & Baron-Borys, J. (1995). Urzeczywistnienie idei integracji na przykładzie działalności Bodelschwinghowych Zakładów "Bethel" [Realization of the Idea of Integration on the Example of the Activities of the "Bethel" Bodelschwing Works]. *Chowanna*, *2*(5), 49–60.

Zdrodowska, M. (2016). Między aktywizmem a akademią. Studia nad niepełnosprawnością [Between Activism and the Academy. Studies on Disability]. *Teksty Drugie*, *5*, 384–403.

Żywicki, D. (2010). Czy osoby słabe, niepełnosprawne są światu potrzebne i dlaczego? [Does the World Need the Weak and Disabled? And Why Would It?]. In: M.D. Filińska, B. Momot & A. Wojciechowski (eds.), *Obecność i nieobecność. Sytuacja człowieka słabego we współczesnej cywilizacji (przyczynek do studium)* [*Presence and Absence. The Situation of a Weak Individual in Modern Civilization (A Contribution to s Study)*] (pp. 25–29). Toruń: Wydawnictwo Naukowe Uniwersytetu Mikołaja Kopernika.