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Disabled people and reconstruction of identity: inclusion or stigmatisation

Summary

Managing social identity, reconstruction of identity, constructing own biography from scratch is something that a person with acquired disability must cope with. People with inborn disability create their identity of a disabled from the beginning. They are prepared/raised/educated to take the part of a person with disabilities in the society. Can a person who acquired disability experience such accelerated adaptation? It is disability that will become the central category which will determine their social identity. In the article the author raises the problems connected with setting up the line between personal and social identity, between satisfying the need to be unique and the need to belong, between defining a person through the prism of stigma (Erving Goffman) and perceiving them as representative of a specific type of personality (Alfred Schutz). How deep is the mark of a person with disability that this disability imprints in their life is best known only by the people who live with it. How difficult is the management of social identity or the reconstruction of biography is best know by them as well. What is the identity created or reconstructed in the process of social stigmatisation going to be like? Is it possible to come out of the process of stigmatisation?

Key words: education to disability, integration, identity, stigmatisation.

The way of perception of disabled people in the society is not typical. Their roles and identities are defined differently by others. Disability becomes a central category which is the main feature defining the social identity of those people. The discrepancies between the transactional identity and the real identity of the individual interferes with interactions, constitutes the space where the marking is possible. Does the person with the acquired disability adapt to the expected social identity and how?

The most important is self-stigmatisation. It is not only that the disabled allow others to treat them with discrimination, which is very often out of their control, but they also start treating themselves in the same way; they "see" themselves with the eyes of others, they internalise the attitude of others. Self-stigmatisation "allows" the disabled to adapt to the demands of society, "allows" to reintegrate the identity. The person treated as disabled begins to behave stereotypically, finding the ascribed characteristics in themselves. Is that the self-stigmatisation or adaptation? Can the body awareness, disabled body awareness make the identity reintegration easier?

The disabled in the lingual world

A disabled person, or a person with disabilities, is the contemporary term for the person defined for many years as "cripple", "invalid", "handicapped", "idiot". These categories are out of use, both in scientific and colloquial language. Now being human is mostly emphasised, there is the definition of dysfunction or deficiency distinctive for a specific person. Now "a person with..." is the most common used expression. First you say "a person" and then you add "with the mobility, intellectual, mental, sensor disability". What is more, there is a tendency to emphasise the specific problem, e.g. "a person with hearing impairment", "a visually impaired person", "a person on a wheelchair", "a person with Down syndrome", "a person with cerebral palsy", etc.

First and foremost, a disabled person is a human being, the information about limitations as with every other person is secondary. If I have a migraine, shall people around me call me "a migraine person" instead of calling me "a human"? No, they shall not. Why then do we think of the disabled like that? Why is there a stereotype in our way of thinking that makes us think of disabilities as first and secondary elements of being human? Why does disability become a central category which defines the social identity of disabled people? Is that just because their disability is more visible? But it is not always visible. In many cases the disabled themselves inform about their disabilities the people that they meet. Why? Because they do not want to cause embarrassment when their "real" identity is discovered. This way they reply to the stereotypes that are in force in the society. They expose themselves to stigmatisation and self-stigmatisation. People with disabilities become the subject of labelling but also they label themselves. They become the "victims" of this process.

Social identity and personal identity

I perceive the concept of identity from the perspective of symbolic interactionism. Identity can be specified as a definition of me and my role or my position in the group and society.[5] Interactionism together with the concept of multiple identities or different ranges of identities can be the answer to many questions connected with continuity, sameness, individuality or integrity of identity. Thinking of the multiplicity of the social self was started by James, for whom human takes part in many interaction contexts so he has many social selves, which is followed by a breakdown of the social individual (James 2002). Pointing to the creation of identity in the social interactions, the nature of transaction is distinctive for interactionism. Connecting the social identity and the personal one with stigma is essential in Erving Goffman's concept, which is the reason for choosing this concept, taking this theoretical perspective, as it allows the analysis of stigma, one of possible stigmata – disability.

In social relations there are usually some expectations, predictions of how other people will behave. Entering social relations the actors assign a specific identity to themselves and to others. The interaction works without interference only if the expected identity is really the identity of the individual. If there are discrepancies between the transactional identity and the real one, the inter-action is disturbed. It becomes the basis for the creation of space where the stigmatisation is possible. If the defect or feature which discredits the individual in having the expected social identity is known to the people around or obvious in direct contacts, such person will be discredited and will have to face the hostile world (Goffman 1986: 41–42). Disabled people with visible dysfunctions are very often discredited. Some defects are difficult to hide so these people are treated through the prism of stigma. There can be different media that inform the world about their disability: a wheelchair, a walking stick, a hearing aid, etc.

Learned or typical ways of behaviour suggest that "normals" treat the stigmatised people as if their stigma was not significant. However, it leads to a great tension between the participants of interaction and it is often perceived as false behaviour. The difference between the ascribed and real identity is connected with the visibility of stigma. It is the basis for the division into discredited and possible to be discredited people made by Goffman. In the situation when defect, dysfunction or specific feature of the individual is not

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[5] Cf. concepts of Strauss, Mead, James, Goffman; see the works of Hałas, Szacki.

visible, the tension is observed in the stigmatised person. It creates the problem of managing the information about that person's disability or defect. The person with stigma is in a permanent state of anxiety (Goffman 1986: 42).

Social identities can be changing but, according to Goffman, each individual has just one biography and the stigma cannot be erased (Goffman 1986: 57). Each person with the stigma of disability uses many identities. Depending on the social situation, such person may present themselves as stigmatised when in different situations they present themselves as "normal", on one occasion they do not provide any information about themselves when in another one they may provide some information. Surrounded by family or "own" people such person can reveal all the truth about themselves.

Personal identity indicates the uniqueness of individual. That kind of identity is based on the assumption that each individual is different than the others and has the ascribed set of social facts and incidents, space and time orientation points. The basis of a person's uniqueness is the statement that such set is a proper one and possible to be ascribed only to this one person, space and time locus is that person's null point. There were also others who took part in the events, but the set of facts and incidents will be different for them. The facts are proper just for one person. There are no two identical life stories, they will always differ in the e.g. perspective – my point of view is mine not yours and likewise.

Ego identity

Goffman defines identity of ego as a subjective feeling of own situation and character, which is gained by the individual in different social experiences (Goffman 1986: 106). Tendency to accept beliefs concerning the identity identical to "normal" people is an irrefutable fact among stigmatised people (Goffman 1986: 7). Goffman claims, "the concept of social identity allows us to consider stigmatisation. The concept of personal identity allows us to consider the role of information control in stigma management. The idea of ego identity allows us to consider what the individual may feel about stigma and its management" (Goffman 1986: 106–107). Goffman argues that the individual usually stigmatised feels some ambivalence connected with his own self. A person accepts some identity standards that are specific for the most of humanity and which for them, as a stigmatised person cannot be fulfilled due to their own identity. Such stigmatised individual perceives himself/herself as "normal", typical, not different

from the others. At the same time the others and they themselves as well define them as a person different than the rest of society (Goffman 1986: 108).

How to find a solution to such a difficult situation, or a way to deal with it? There are many recommended models of action, but all agree that the stigmatised person should not completely pass or smuggle the stigmatising information about themselves. Hiding creates huge tension which is very difficult to be managed. Accepting the negative attitude of others towards the stigmatised as his/her own is also not good way of dealing with own frailty. Goffman writes about two more important recommendations. Firstly, a stigmatised person should not totally surrender to the imposed role. Secondly, they should not accept the extreme attitude, they cannot consider themselves fully "normal". Failure to comply with the first recommendation leads to inauthenticity, to accepting the role of a person that the stigmatised is not and does not feel to be one (Goffman 1986: 110). These models of action are not only instructions how to treat others, but first of all they are the ways to have a proper attitude towards themselves.

Stigmatisation and self-stigmatisation

The identity of individual, created or reconstructed in the process of stigmatisation changes – a healthy person becomes a sick one because of the labelling, a fit one becomes a limping one, "cripple", in a wheelchair, visually impaired (Goffman 1986: 54–62). Using the examples from other social situations we can say that a person transforms from a good father of the family into an abusing father. The individual is not even aware that he/she has the specific expectations toward the others, his/her attitude is visible when the person is not like in the model, when they do not fulfil the expectations or do not have all the qualities that were ascribed to them. In such situation the specific person changes into the stigmatised one. Certain patterns of interpretations allow the people around to treat and accept the individual as "such person" and thanks to the labelling accepted by that individual as the one describing them, the inter-action works without any interference (Krzemiński 2002: 158). The stigmatising or labelling may be presented as forcing the individual by the public to accept the particular definition of the situation.

When the expectations concerning somebody's social identity are different than the real one, the possibility to stigmatising appears (Goffman 1986: 2–3). The resource of person's experiences, typical ways of behaviour, in the Goffman's

concept of tact indicate that the individual should be treated in a specific manner if he/she has a particular set of characteristics, we should define that person as physically fit and this way we label that person. In the situation when a person has a particular set of characteristics nobody pays attention. As mentioned above – the interaction works without any interference.

Stigma can be perceived from the perspective of the stigmatised person who knows that their difference is known and visible instantly – in other words, it is the perspective of a discredited person. There is also the perspective of a person who may be discredited i.e. their difference is not known or visible instantly, but it can be noticed at any moment. People with the stigma of disability or other often merge those two perspectives (Goffman 1986: 4)[6].

The so-called "normal" society creates different theories, which allow or enshrine the discrimination of people who are more or less stigmatised. This way stigmatised people are deprived of many rights, privileges or duties. But not only rights, privileges and duties are important here. A fit person may have many reasons not to be able to exercise their rights. In this context for a human being, especially the stigmatised one, the most important thing is inextricably linked to refusal, to deprivation of rights, privileges and duties – it is the feeling of exclusion from the society of "normals", the so-called majority, life in the margins or outside the margin. Acceptance is what stigmatised people lack the most.

Stigma: exclusion and inclusion

There are some common points in Goffman's stigmatisation concept and Alfred Schutz's typification concept. Typification is connected with every aspect of human life. Incidents in the world, types of action as well as actors are all subjects to typification. Just like stigma determines human fate, the scenario of his/her life, also a type determines and limits person's possibilities. If somebody has been ascribed a particular type, if he realises some scheme, it is very difficult for him to change anything. According to Schutz it is not a person or personal type that has been changed but it is the wrong type that they have been ascribed.

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[6] We can doubt if the stigma is always a bad thing for the stigmatised. Some stigmatised persons treat the stigma as grace, good. They say that their life without the sigma would look completely different and they want to live the life they have.

Stigma makes a person stand out in a negative sense, such person is the one with a defect or frailty. Typification also marks a person – it does not matter if it is in a positive or negative sense. This marking has the opposite effect than stigmatisation, it gives the opposite result. Such person is inscribed in the scheme, they are assigned to some type, they blend into the background. They are not individual, this is not Peter I met on my holiday, who had one leg shorter than the other and knew how to pick mushrooms. He is disabled and he belongs to a group of people whose characteristics are legs of a different length. On the one hand, this defect is a stigma as it differentiates the individual from the group of people with legs of the same length, it shows his distinctness, it separates him from the society. On the other hand, it can be used as a typification factor and on that basis Peter is ascribed to the group of people with a similar defect, he is assigned to a type of a kind and depending on a level of typification he becomes to be an anonymous individual.

The dependence between the kind of social relation and the level of anonymity type is significant. In the face-to-face relation stigma is imposed with all its strength when the type does not matter. With the increase in anonymity of social relation the type becomes important and the significance of stigma decreases. In an anonymous social relation two types take part, not the particular individuals (Schutz 1972: 180–181; Lejzerowicz-Zajączkowska 2003: 161–163). Stigma is important only as a characteristic that assigns the person to a particular group, e.g. people with legs of a different length. It is not important any longer what the individual's defect is. Like in every typification individual characteristics are not important any more, it does not matter if they are old, young, intelligent or not, etc. I want to emphasise that stigma may occur simultaneously as some-thing that distinguishes and as something that makes the typification possible.

It is essential that significant others treat that someone like a human, regardless of his/her stigma, which may be a disability. We see ourselves through the picture in the eyes of other people, we are as the others want to see us or really see us. Identity is socially given, but it is also maintained socially – when the social identity of a person changes, soon after that their own picture changes. Berger claims that the society delivers the scenario for all its members, like in theatre or a movie. The scenario says what actor is supposed to do, what character he/she plays and how to do it (Berger 2001: 93–99).

Transactional identities – a way to inclusion?

Relations with "normals" that stigmatised people with a hard to notice stigma enter is the main field of Goffman's interest. He does not deal with the relations of the people with a stigma visible at first sight or a completely invisible one. However, those two situations are also worth being considered. I analyse the first of the abovementioned situations, i.e. the situation of entering the relations with "normals" among the people with visible defects. "Normals" treat such person differently than they treat ordinary people who do not have stigma. For instance, a blind person is treated as a person with mobility problems, some people would like to "help" them by carrying them across the street or carrying them into the bus, etc. A blind person or a person with some other defect is not treated as a full member of interaction or a full member of society, as a "full" person. It is expected from a blind, deaf or immobilised person to behave according to social identity ascribed to them (according to the central category which organises their life). They are expected to play their role of a person with disability not to cause any embarrassment, confusion due to wrongly assigned identity. A stigmatised person must adapt, not a "normal" one. "Normals" care about their sense of well-being, they do not care about the feelings of minority (Goffman 1986).

The person with a disability stigma allows not only being treated in a discriminatory manner, which they sometimes cannot do anything about, but also starts to treat themselves this way, they perceive themselves this way, "see" themselves with the eyes of others, they internalise their attitude. Self-stigmatisation "allows" adapting to society requirements, "allows" harmonising identity. Self-stigmatisation is very important here. A person treated as disabled begins to behave stereotypically, they find the characteristics that are ascribed to them. The labelling is pinned, so one has to live with it. The aforementioned situation is described by Goffman with the use of example from Finn Carling's work:

(...) the cripple must be careful not to act differently from what people expect him to do. Above all they expect the cripple to be crippled; to be disabled and helpless. (...) It is rather strange, but the cripple has to play the part of the cripple, just as many women have to be what the men expect them to be, just women (...).

I once knew a dwarf who was a very pathetic example of this, indeed. She was very small, about four feet tall, and she was extremely well educated. In front of people, however, she was very careful not to be anything other than 'the dwarf' and she played the part of the fool with the same mocking laughter and the same quick, funny movements that have been the

characteristics of fools ever since the royal courts of the Middle Ages. Only when she was among friends, she could throw away her cap and bells and dare to be the woman she really was: intelligent, sad and very lonely (Carling 1962: 54–55).

Stigma allows the majority of society to ascribe typical social identities to the disabled because of stereotypes. Those social identities are connected with particular social roles. The disabled are perceived through stereotypes present in society, e.g. a disabled person is often perceived as eternal child, who will never grow to be independent, who will always need help from others. Another stereotype classifies a disabled person as poor. And yet another, connected with the previous one, that a disabled is to be regrettable, deserves pity because of his/her condition. Such unfortunate thing happened to him/her and his/her parents or caretakers and they all have to endure it and live with it to the end (Chodkowska et al. 2010; Abramowska 2005: 191–198). It is usual that people think of such person as a very unhappy one and according to the world this person also contributes to unhappiness of others. But escape from this stereotype may lead to another one, treating disability as a disease. It is often heard that instead of saying "I have a shorter leg" such person says "I have a shorter limb". Using the medical language is one of the manifestations of stereotypes (Abramowska 2005: 192). That is the consequence of social acceptance of a medical model of disability. Medical approach to disability leads to objectification of the approach to disability by the disabled themselves. Other mentioned stereotypes include marking by God or being dangerous due to excessive physical development. But the most common stereotype arising from the lack of knowledge of the disabled is the conviction that the disabled "endanger the safety of individual and his family". In everyday life society treats the group of disabled people as the uncertain one, "it is never known what they can do" (Abramowska 2005: 192). Those stereotypical features are ascribed to the disabled individuals by the society, the society pins other labels, ascribes certain social roles connected with those stereotypes and expects the disabled to accept those roles.

People with disabilities – social image

It is difficult to change somebody's own image or social identity, both among the people with disabilities and those without them. It is difficult to eradicate habits, it is difficult for the disabled to learn that they have the same rights as

other people. It may result from the disability perception models, which were described by Władysław Dykcik (2003), but also from the disability models being in force currently and from the stereotypes and prejudices in the society towards the disabled. We often perceive the disabled through that prism. If we do not know the person with a specific problem directly, we ascribe to them some characteristics that we think they should have or do have. We ascribe some personal type to them or assign them to a particular group of people.

The social model of perceiving disability is more widespread, but I want to emphasise that it is only the declared attitude that changes, not the real attitude (CBOS 2007). The declared attitudes towards the disabled have nothing to do with reality. The declared acceptance is a desired state of affairs, we would like our relations to be like that, when the real acceptance is a different problem and it does not often appear in our social reality. Stereotypes and prejudices change but it is a very long-lasting process.

It is worth thinking whether such integration, inclusion, normalisation is necessary to us, the so-called majority or to them – the social minority. On the one hand a man wants to be special, on the other he wants to be normal, just like others. It is connected with the common problem of drawing the line between personal identity and the social one, between fulfilling the need to be special and the need to belong. Only the people who live with disability know how difficult it is to draw such a line and how big the stigma is.

Identity management

Identity is built by a person for a very long time. What happens in the situation when suddenly an accident causes that a beautiful woman becomes a woman with a deformed body, what happens to such person's identity? Does it change, is it the same identity as before the accident? What happens to the identity of a fit person who had a stroke and becomes a person with hemiparesis? What happens when someone acquires a disability? When suddenly a healthy adorable young man has to start using a wheelchair and becomes a regrettable young man? Psychological concepts describe the stages of getting through the loss of being fit; one of the most known is Nancy Kerr's concept, according to which people with acquired disability come through the process of dealing with loss, not necessarily ending successfully. There are six stages: shock, expecting

recovery, phase of wailing, adaptation or healthy defence, neurotic defence, phase of adaptation (Kerr 1977). Reaction to an accident, disability due to an accident or disability connected with a disease can be compared to the reaction to the death of a close person or to the information of a fatal disease that affects us (Kuebler-Ross 2006; Wolski 2010: 28–38; Piotrowski 2010)[7]. As a result of acquiring a disability a person is in a borderline situation, their whole life changes. Disability impairs all zones of their life. There appears the need to reorganise the whole life in its every aspect, both for the disabled person and for his/her close persons. The self-image in somatic, mental and social areas changes. Previous identity is not valid any more, the human becomes a stranger, a different person for himself/herself. All other social roles he/she performed until now are suspended. The human being is as if transferred to another world which he/she is not able to live in, which is not his/her world, he/she is a stranger in his/her own house. Such person stops to be independent, self-sufficient, they lose the sense of control.

Referring to Goffman's concept I will emphasise that when people become disabled they do not instantly obtain the social identity of the disabled, their current "normal" identity stays a for shorter or longer period of time, also their personal identity and ego identity stay without change. So there is a question when this change, the identity reconstruction takes place, what changes in the personal and ego identity of this person. What is the relation between the constituting/reconstructed social identity of the disabled on a wheelchair with labels and his ego identity which can be described as: me – young, go-ahead, pursuing a career, rich, admired? Is the personal image in contradiction with the social image and will it stay like that? How can it be consistent, what if it stays completely different? How to function with constant tension in relations between the identity ranges? Can the identity crisis be constant?

Becoming disabled, noticing one's own dysfunction and impossibility to remove it, in the first period of disability leads to an identity crisis. An individual notices that he/she is not the same person any more, the ego identity zone is disturbed, I am dependent on others, I have no sense of autonomy, my separateness zone is disturbed, the continuity of I is disturbed, I have no sense

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[7] Kübler-Ross (2006) distinguishes five phases of living through the sickness loss. These are: denial and isolation (shock), anger, negotiations, initial depression, acceptance and increased independence. The model of stage-based dealing with the loss of being fit that uses previous research of dealing with the loss is described by Wolski (2010: 28–38). He also distinguishes five stages of dealing with loss: shock and denial, anger, bargaining, depression, acceptance.

of integrity (Brzezińska 2006: 49; Wolski 2010: 25). Identity reconstruction, finding life aims different than before is a very difficult and complex process which very often ends in failure.[8] Becoming disabled determines self-perception. Allowing irreversibility of losing fitness to get into consciousness, allowing the changes in physical, mental and social image to get into consciousness, which is connected with the perception of such person by the others, leads to changes in social, professional and family roles, often to discontinuation of fulfilling the professional role and to exclusion from many social roles. Later on adaptation appears, such person must limit their aspirations with implementing their defensive mechanisms, e.g. valuing their social or professional roles less, lowering their self-esteem (Baranowska 2005: 6; Jakubik 2001: 53–57). The role of significant others is important, as well as the support of the institution or social environment.

Referring to the concept of social roles in the adaptation to the new way of living process the following stages can be distinguished:

- Withdrawal from the previously fulfilled roles;
- Identification with the new roles;
- Improvement in the new roles;
- Integration of the new roles with the previous ones (Baranowska 2005: 4).

Reorganisation of current identity or lifestyle is based on the previous lifestyle and identity, on previous resources, socio-cultural assets owned by the individual, and many other factors. The following are essential:

- "Type and level of damage, the more visible it is, the more it disturbs normal living, the more difficult it is to accept it;
- Dysfunction or disease duration time, annoyance, degree of endangering life;
- Individual characteristics (age, sex, personality, education, fulfilled roles);
- The range and type of social contacts – presence of others can be stimulating or adverse if they show pity, repulsion or rejection;
- Economic situation – possible chance of undergoing the body reconstruction surgery or purchase of specialised equipment which makes life easier, e.g. prosthetics, wheelchairs" (Baranowska 2005: 4; Jakubik 2001: 53–57).

The content of sad experiences concerns the most important aspects of life. David Krueger (1984) points out that the most traumatic experiences connected

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[8] Also Kowalik (2007: 55–57) shows that some people are not able to overcome the crisis caused by disability; he emphasises this aspect when analysing the process of sequential adapting to disabilities and linear types of adapting.

with acquisition of disability associated with e.g. body defect concern mostly adults who attained disability unforeseeably, unexpectedly. Children with inborn disability develop their own self taking into account the existing problem of defect or deficiency. That is the immanent element of their concept of self. They acquire knowledge of their disability gradually, most often they are informed by their parents, caretakers or significant others. It gives them time to mentally adapt to their disability. Pain, suffering in that situation has no nature of a violent mental trauma. On the other hand it may lead to the creation of a spoiled identity or a homilopathic identity, as it was defined by Andrzej Jakubik (Jakubik 2001: 53–57).

People with inborn disability from the beginning form their identity of a disabled person. Since birth they are prepared/raised/educated to take the role of a disabled person in the society. Should the person who acquires a disability undergo such accelerated adaptation? Does such person really want to take the role of a disabled person in our society? Do they even have a chance to make a choice if their disability is the main organising category which arranges their life? Taking into account the personal type which the person represents, society will ascribe to them the role of a disabled person. Does such person make a conscious choice to get into this role? Or are they forced by the social expectations?

Trauma associated with body damage depends not only on the abruptness of defect and time of its appearance. Stanisław Kowalik (1998) claims that this size is determined also by the size and location of body damage, its influence of general condition, visibility of the defect, noticed possibility of physical restitution of damage, previous body damage experience, memory of accident which caused the damage and identity characteristics of a disabled individual.

Assuming that there is a possibility of managing the identity or identities, is it easier for people with disabilities to function in the society in a changing environment? Does identity management allow acceptance of such identity which suits us or the one which is imposed on us by the people around? Does having ego identity protect the disabled from stigmatisation? With the chance of taking on the social identities, presenting self in this or that way, it would seem that we have a chance to present ourselves in a beneficial manner. I would agree but only in situations so widely described by Goffman. Namely presenting ourselves in a better light, presenting our better sides, which is only possible when we can hide, pass some information about ourselves, then the stigma is not visible instantly. But in the situation when the stigma is imposed forcefully it becomes the main category which is the basis for defining the social identity

of a person. In the situation when after gaining the disability a person is constantly hit with their image changed by the disability, other perception of themselves from the others, especially the significant others, when they still receive the information that they are disabled, that they cannot function on their own, that they cannot make themselves coffee or another simple thing, that they are dependent on others, they get the image of a person that needs to be helped, who experienced something so unfortunate, how long will they manage to put up with their own image, how long will their ego identity stay unchanged? They additionally get the message that they have to accept their condition and that nothing will change, but they have to change themselves. The society expects them to adapt, to take in the offered image, they are forced to take in the definition of the situation (Butler 1997: 98–104; Koczanowicz 2005: 80, 88–90).[9] The ranges of identity listed by Goffman are inextricably linked. In the situation of gaining disability, the changes of social and personal identity determine the changes in ego identity.

Conclusion

Individuals build their identity, they place themselves "on the map of structure and prestige", they are inclined to adopt a particular role in the closest environment and to classify themselves in a particular place of the social identification structures.[10] What prompts an individual to assume a specific transactional identity are benefits it can bring. One of the basic human needs is to meet the need to belong. Inclusion is much more desirable than exclusion. Even if it is affiliation to a group demonstrating deprecating attitudes. If a person can manage available identity, if it is being upheld socially, it can be a way to adapt. However, does self-image will also be adopted? We see ourselves through our image in the eyes of other people, we are what the others want to see in us.

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[9] Judith Butler (1997) points out the tension, some paradox in the constitution of identity. She believes, according to Koczanowicz (2005), that a man is prone to accept the definitions which are socially degradable only if they also constitute the social identity. Butler shows this paradox as something very important in the analysis of sex identity.

[10] R. Scott and E. Goffman show that socialisation of a disabled person is a preparation for the role of the disabled. Institutions which provide different forms of care, education and help have the specific meaning in those processes. The power of their influence moderated with the length and level of excluding the subject from natural forms of socialisation and including him into the reach of those institutions is important part of building the identity of individual.

Becoming disabled or living with a disease is commonly perceived in the category of failure. Disability, disease are in odds with the contemporary types of success, career or personality that are promoted in social life.

Autonomy and independence of the disabled is very often limited; being self-sufficient and independent cannot be taught in the care centres that operate in isolation from everyday issues and problems (Kwiatkowska 2003: 67–79). Becoming disabled or experiencing a disease leads to exclusion and social marginalisation. It is in isolation and on the margins of society that the person is to rebuild their identity or to create a false transactional identity if only to be included, to be "normal".

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