

CHAPTER 10 (In 'Disability Studies: Past Present and Future' edited by Len Barton and Mike Oliver (1997); Leeds: The Disability Press, pp. 160 – 178)..

The Concept of Oppression and the Development of a Social Theory of Disability

Paul Abberley

(First published 1987)

I would like to preface this article with some short autobiographical notes, not because I think these are ultimately relevant to the adequacy or otherwise of the ideas put forward, but rather because an understanding of the context in which the material was produced may make clearer the reasons behind certain concerns and emphases.

At the age of five I contracted poliomyelitis in the last major epidemic of the disease to occur in this country. I spent six weeks in an iron lung, eight months in a hospital bed, and by the age of seven had regained sufficient mobility to attend a state primary school. Some 25 years later, working as a lecturer in sociology, I began to receive requests from some of my colleagues to talk to their students about 'disability'. My first response was one of annoyance and resentment, since I had spent most of my life, as many 'successful' disabled people do, attempting as far as possible to deny and ignore what is in fact a very obvious collection of impairments. But beyond this, I felt that, as a sociologist, I had nothing to say about disability, since the small amount of academic material I was familiar with struck me as both inadequate as an explanation of my own experiences and quite foreign to what I considered 'good sociology'.

Further investigation, during a year's study leave at the University of Warwick, convinced me that, with a few notable exceptions, the sociology of disability is both theoretically backward and a hindrance rather than a help to disabled people. In particular it has ignored the implications of significant advances made in the last 15 years in the study of sexual and racial inequality, and reproduces in the study of disability parallel deficiencies to those found in what is now seen by many as racist and sexist sociology. Another aspect of 'good sociology' that I feel is generally absent is any significant recognition of the historical specificity of the experience of disability. In my own case, had I been born a few years earlier, before the development of respiratory support systems, I would have died; a few years later and the advent of effective vaccination techniques would have made my contraction of the disease

improbable. In view of this, and similar related considerations, I came to understand my own disabilities in terms of a unique conjunction of factors, a view which I now try to apply to disabled people in general. It is on the basis of such ideas about myself as a disabled person that the following work has been produced.

A number of writers (Oliver, 1986) have employed the term 'oppression' in the analysis of disability. However, the meaning attached to this term is ill-specified. Oliver, for example, in an earlier draft of his paper, though not in the published version, where any attempt to give precise meaning is absent, uses it interchangeably with exploitation, and it is not defined but rather seen as an 'obvious' but difficult to substantiate characteristic of 'social relations under capitalism'. While this is clearly an advance on the 'personal tragedy theory of disability' criticised in the same article, for the notion of oppression to be a useful one the term must be more clearly specified, both in general and in relation to disability in particular.

To draw an analogy between disabled people and groups to whom the term oppression has been applied is by no means a new occurrence. In the literature of disability a number of studies comment, but no more than comment, on the similarity between disabled/normal interactions and those encountered in studies of race relations. Barker for example remarked as long ago as 1948: "the physically disabled person is in a position not unlike the Negro, the Jew and other underprivileged racial and religious minorities," (Barker, 1948, p. 31) while Handel in 1960 observed that his report "sounded as though we were considering a problem of race relations instead of disability" (Handel, 1960, p. 363). Again Chesler in 1965 claims to have found that individuals manifesting high ethnocentrism, or high rejection of outgroups, also expressed rejection of the physically disabled (Chesler, 1965, pp. 877-882).

A recent study in the *Journal of Maxillo-facial Surgery*, reported in *New Society* in June 1985, claims that on the basis of a photograph study "children don't start reacting badly to abnormal looks until they are at least 11 years old" and that consequently "discrimination against funny-looking people is not some innate result of evolutionary forces, it is socially learned" (*New Society*, 1985). There is a striking parallel here to Davey's book length study of racism and its acquisition (Davey, 1983). Interestingly, amongst the studies reported in this volume is one (Richardson and Green, 1971) where it was found in a sample of white children in London schools that visible physical handicap was a greater deterrent to friendship than blackness. In Davey's discussion this is regarded as an 'encouraging' finding!

(op. cit., 113). But despite observations and insights of this kind, the sociological literature of disability has carried such ideas no further.

Indeed, the oft-quoted Davis asserts: "Because the visibly handicapped do not comprise a distinct minority group or subculture, the imputations of generalized deviance that they elicit from many normals are more nearly genuine interactional emergents than the conventionalized sequelae to intergroup stereotyping, as for example, might obtain between a Negro and white" (Davis 1961:122). Yet there is no argument *per se* for this position. Rather Davis gives an illustrated Interactionist account, made 'special' by its emphasis on 'coping' behaviour, and concludes by emphasising a similarity to and continuity with 'normal' interaction. The focus of Davis's analysis upon personal interactions and the denial of any generalised group membership, "reduces the issue of disability to a 'deviance' progressively dissolved in repeated interactions with particular individuals, only to be re-encountered on each new acquaintance.

It is clear then that if the notion of oppression is to be of use in the analysis of disability in society, and most importantly of use to disabled people in understanding and transforming their own situation, we must clarify and develop what is meant by the term.

THE CONCEPT OF OPPRESSION

Given the complexity of theoretical issues surrounding theories of oppression, (Barrett, 1981; Jaggard, 1983; Brittan and Maynard, 1984) at this stage it is possible to say only in broad outline how a theory of oppression could inform our understanding of the situation of disabled people in Britain today. To argue that we need to analyse the position of disabled people as a form of oppression is not to make the claim that we can arrive at a monolithic theory of oppression into which we can fit women, black people, disabled people or gay people depending on which particular oppressed group is under discussion at the time. A crucial feature of oppression and the way it operates is its specificity, of form, content and location; so to analyse the oppression of disabled people in part involves pointing to the essential differences between their lives and those of other sections of society, including those who are, in other ways, oppressed. It is also important to note that probably more than half of disabled people in Britain today suffer the additional burden of racial and/or sexual oppression (Campling, 1981; Confederation of Indian Organizations (U.K.), 1986).

To claim that disabled people are oppressed involves, however, arguing a number of other points. At an empirical level, it is to argue that on significant

dimensions disabled people can be regarded as a group whose members are in an inferior position to other members of society because they are disabled people. It is also to argue that these disadvantages are dialectically related to an ideology or group of ideologies which justify and perpetuate this situation. Beyond this it is to make the claim that such disadvantages and their supporting ideologies are neither natural nor inevitable. Finally it involves the identification of some beneficiary of this state of affairs.

The term oppression, while regularly encountered in discussion of racial and sexual disadvantage and of the 'national question', does not appear in encyclopedias of social science, nor in the generally useful *Dictionary of Marxist Thought* (Bottomore, 1983). *Collins English Dictionary* gives four meanings for the word oppress:

- (1) to subjugate by cruelty, force, etc.;
- (2) to lie heavy on (the mind, imagination, etc.);
- (3) to afflict or torment;
- (4) an obsolete word for overwhelm.

In talking of racial or sexual oppression we are clearly not employing any one of these definitions, although aspects of all four meanings are contained within the term, whose use has developed in relation, and complementary, to classical Marxist class analysis. Class analysis *per se* has emerged as an unsatisfactory tool for the analysis of racial and sexual disadvantage, which is experienced in addition to, or perhaps more accurately through, people's class experiences. It is to such sets of experiences that the concept of oppression is addressed.

Oppression and exploitation are not equivalent concepts.... Exploitation speaks to the economic reality of capitalist class relations for men and women, whereas oppression refers to women and minorities defined within patriarchal, racist and capitalist relations. Exploitation is what happens to men and women workers in the labour force; woman's oppression occurs from the relations that define her existence in the patriarchal sexual hierarchy-as mother, domestic labourer and consumer. Racial oppression locates her within the racist division of society alongside her exploitation and sexual oppression. Oppression is inclusive of exploitation but reflects a more complex reality. Power-or the converse, oppression-derives from sex, race and class, and this is manifested through both the material and ideological dimensions of patriarchy, racism and capitalism. Oppression reflects the hierarchical relations of the sexual and racial division of society. (Eisenstein, 1979: 22-3)

For this author oppression is not an alternative explanatory device to exploitation, rather it is addressed to a different order of phenomena, those connected with a person's gender or race experiences rather than their class experiences. Oppression is complementary to exploitation, extending the range of Marxist analysis to cover areas the latter concept cannot reach.

In developing theories of sexual and racial oppression it has been necessary for theoreticians of the women's and anti-racist movements to settle accounts with biology, which in both cases has been employed to explain and to justify social disadvantage. For a theory of disability as oppression however an important difference arises when we consider the issue of impairment. While in the cases of sexual and racial oppression, biological difference serves only as a qualificatory condition of a wholly ideological oppression, for disabled people the biological difference, albeit as I shall argue itself a consequence of social practices, is itself a part of the oppression. It is crucial that a theory of disability as oppression comes to grips with this 'real' inferiority, since it forms a bedrock upon which justificatory oppressive theories are based and, psychologically, an immense impediment to the development of political consciousness amongst disabled people. Such a development is systematically blocked through the naturalisation of impairment.

Further, the evaluative connotations are cognitively as well as effectively contained in terms which themselves imply deficiency, in contrast to 'woman' and 'black'. This is not to suggest that perceptions can be changed by changing words but to point to the deeply entrenched rejection of 'impairment' as a viable form of life and to the 'commonsense', 'natural' and 'unconscious' nature of ideologies of impairment, disability and handicap. This rejection of the authenticity of impaired life forms is exhibited both in the obvious form of what Dartington, Miller and Gwynne (1981) call the "less than whole person" view, and its inverse, the "really normal" ideology, which finds its expression in everyday life in the exceptionalism of 'but I don't think of you as disabled', denying a key aspect of a disabled person's identity in what is intended as a compliment. Compare this phrase to 'played like a white man' and 'she thinks like a man'.

What is required is essentially an attitude of ambivalence towards impairment, that is "co-existence in one person of love and hate towards the same object" *Concise Oxford Dictionary* (1964). Impairment must be identified as a bad thing, insofar as it is an undesirable consequence of a distorted social development, at the same time as it is held to be a positive attribute of the individual who is impaired. An analogy may be drawn here with the feminist treatment of so-called 'women's troubles'. The key

distinction that must be made is between the prevention of impairment, on the one hand, and attitudes to and treatment of people who are already impaired on the other.

A pertinent recent example of the necessity for such a distinction is displayed in the boycotting of the 1985 Manchester International Conference on Education of the Deaf by the British Deaf Association and the National Union of the Deaf. "The objection is that the main discussion will be the development of electrode implants, which have the potential to restore 'hearing' even to the totally deaf, provided that they once could hear" (*The Guardian* 5 8 85). The education chairman of the National Deaf Children's Society said that deaf children could lead a full life using other forms of communication such as sign language. "They shouldn't get the idea that the thing is to be more like a hearing person at any cost" he said (*ibid.*). While the boycotters' attitude to impairment is one of ambivalence, as defined above, and thus of respect for disabled people, the members of the medical profession who determined the agenda clearly expressed their own rejection of the disabled state by determining that a dubious 'rectification' procedure, to which they raised only *technical* objections, should be the main business of a conference which occurs once every five years.

Yet if the inferiority embodied in impairment is understood as purely or primarily biological in origin, the suggested analogy with racial and sexual oppression appears to be an inherently dubious one, since the core of such theories is that disadvantage is ultimately a social and not a biological product. A theory of disability as oppression then must offer what is essentially a social theory of impairment.

IMPAIRMENT AS A SOCIAL PRODUCT

The general tendency within medicine has been to attribute most impairments which are not identified as the consequence of acute illness and infection to 'normal' wear and tear on the human body. Causation, on this view, is ascribed either to 'germs' or to 'life'. Any 'social' involvement is presented as secondary or peripheral to the major identified patterns of 'natural' causation. But an alternative account of the origin of impairments is at least as viable.

To take the major cause of impairment in Britain, some five million people are thought to suffer from osteo-arthritis, and some one million from rheumatoid arthritis (British League Against Rheumatism, 1977). While often regarded as 'simply' a degenerative process, "a number of rheumatic problems are known to arise in connection with various occupations. Unfortunately economic factors have usually not allowed this knowledge to be fully exploited. Primary prevention would call for changes in methods of

working and in the job environment, and these are often costly" (Arthritis & Rheumatism Council (n.d.: 11)). Thus an alternative view of this major cause of impairment would locate explanation not at the 'natural' or 'individual' level, but in the socioeconomic context of its occurrence, of which 'physical degeneration' is by no means an independent variable. To extend this argument further, the pace and direction of the development of preventative and ameliorative techniques are - themselves the product of socio-economic factors, which are in turn effected by what are fundamentally political decisions. Thus at both these levels social aspects of impairment causation may be discerned.

Whilst most incapacity resulting from injury sustained at work is categorised as of relatively short duration, about a third results in permanent or possibly permanent damage (Pearson, 1978). In addition to accidents, some 16,000 people a year contract an industrial disease as prescribed under the 1975 Social Security Act, the main categories being infective dermatitis (10,000), traumatic inflammation of the tendon (3400) and bent knee (1000). However, the comparison of such statistics, based on DHSS records which exclude certain diseases known to be caused or exacerbated by industrial injury, to a personal injury survey, led Pearson to conclude:

There were substantial numbers of illnesses where there appeared to the sufferer to be a probable link between the illness and conditions of work, possibly amounting to five times the number of prescribed diseases recorded by the DHSS (Pearson, 1978, Vol. 2:66)

Nichols (1986) echoes this sentiment, as have other writers who argue that official figures on work-based impairments constitute merely the tip of the iceberg (Kinnersley, 1973; Thunhurst, 1982; Navarro, 1982), and argues further that since 1978 the rate of disabling injuries and deaths in manufacturing industry has increased.

Mirroring impairment caused by the process of production is that attributable to the willing or unwilling consumption of its products. While perhaps the most notorious example in Britain is the drug Thalidomide, other products of the pharmaceutical industry are, or should be, similarly implicated. Of the 70,000 personal injuries attributed by Pearson to defective products or services (about 2¹/₂% of all injuries) around half involved prescribed drugs.

At the World Mental Health Congress in Brighton in July 1985, Dr David Hill, Senior Psychologist at Walton Hospital, Chesterfield, argued that 25 million patients throughout the world had suffered irreversible brain damage as the

result of the administration of powerful tranquillisers such as Largactil (*The Guardian*). His critics made no attempt to rebut this contention, but simply averred that there was no alternative.

At a world level, the deleterious health effects of prescribed drugs is chillingly documented (Muller, 1982). While, in the 'developed' world, at least, vaccination has reduced to a trickle the number of cases of many diseases, vaccine-related damage has itself caused impairment, in those who have paid the individual cost of general health improvement. The development of effective vaccination techniques has also had the paradoxical effect in some cases of disadvantaging those who have already been impaired by a disease. For example:

The end of the recurrent epidemics of polio meant that the disease, and therefore its victims, lost their high profile. There was a reduction in new research on the disease, its process, and its management. This meant that knowledge about the epidemiology and pathology of polio has been essentially stalled at the level of medical knowledge in the mid-1950s.... Part of the context of any particular disability is its topicality in the medical or in the public eye. Like cancer today, polio once attracted attention beyond its actual level of threat to the population; however, once immunization removed that threat, polio became a 'non-issue'. (Kaufert & Kaufert, 1984: 616)

It should be noted that any removal of the threat of polio is only a local one. Contrary to general medical belief in the 1940s and 1950s, polio is by no means a 'disease of civilisation'; recurrent outbreaks are still endemic in much of the world, where vaccination has been seen as unnecessary or where methods of administration have been ineffective.

It is estimated that the world population of disabled people is around 500 million, over two-thirds of whom live in developing countries, and that one in ten of the world's children is physically or mentally disabled. Some authorities argue that up to 50% of world disablement is either preventable or significantly rehabilitable at a cost of a few pounds per head (Shirley, 1983). For example around 6000 children go blind each year in Tamil Nadu due to easily remediable vitamin A deficiency. Yet Dr Michael Irwin, UNICEF co-ordinator for the International Year of Disabled People said, "only 1 or 2% of the disabled children in the Third World are reached by any rehabilitation" (*The Guardian*, 1981). Another major contributory factor in the aetiology of impairment is nutrition; yet it is universally recognised that world food supplies exceed world need, and that malnutrition today is a consequence of

political decisions, not 'acts of God'. As far as the majority of the world's disabled people are concerned, impairment is very clearly primarily the consequence of social and political factors, not an unavoidable 'fact of nature'.

Returning to the developed world, advances in medicine have had the effect of increasing the survival rate of previously 'non-viable' individuals, producing an increased proportion of severely and multiply impaired young people-the improved survival rates of people suffering from Down's syndrome and spina bifida are cases in point. The generally unquantified effects of environmental pollution, and the impairing effects of the - consumption of foodstuffs, tobacco and alcohol on individuals and their future offspring must also be noted, although here I will deal with these aspects no further.

Impairment may result from so-called hereditary factors or injury incurred at or soon after birth. Data from the National Child Development Study showed an incidence of serious defects which were congenital or had arisen shortly after birth as 30.8 per thousand live births. By seven years old the incidence was 19.6 per thousand, about half resulting in disablement. A further nine children had very poor sight, and three per thousand poor hearing (Davie *et al.*, 1972). The example of Phenylketonuria (PK.U) reveals the complex interconnection between congenital and social factors in the production of impairment. This hereditary inability to metabolise the aminoacid phenylalanine may today be detected and, through dietary control, mental retardation be prevented. Prior to the development of methods of detection and treatment, it may have appeared eminently reasonable to characterise the disorder as a congenital one; it would now appear equally correct to characterise it as socially determined, in that only individuals born in environments in which tests for the presence of the PK.U. phenotype are not conducted, and where there is no available treatment, will suffer the subsequent impairment. It would thus seem impossible to adequately draw a dividing line between genetic and environmental, and thus ultimately social, factors. Rather, the designation of genetic factors as primarily causative is itself a judgement determined by knowledge, interest and intention, in other words, a political judgement.

It is possible at this point to clarify the nature of the claim that *impairment* is to be understood as social in origin, and to distinguish it from the more usual sociological generalisations about the social origins of *handicap*. The latter position, at least in its more worked out forms, presents handicap as totally the product of social meanings, in other words as reducible to 'attitudes'. It implies that a change in attitudes could abolish disability. Claims about the social

origin of impairment, however, are directed at the explication of the social origin of what are material and biological phenomena, and should be understood not as dissolving these material elements into attitudes or ideas, but rather as pointing to the inextricable and essential social elements in what constitutes a material base for ideological phenomena. Thus such a view does not deny the significance of germs, genes and trauma, but rather points out that their effects are only ever apparent in a real social and historical context, whose nature is determined by a complex interaction of material and non-material factors. For example, while the link between tobacco consumption and lung cancer, bronchitis and ischaemic heart disease is demonstrably a material one, the occurrence and incidence of tobacco consumption is to be understood primarily in terms of social factors, as is the level and kind of ameliorative provision available.

At a political level, focusing upon kinds and rates of impairment, posing as they do in an explicit and graphic form the contradictions between the potentially beneficial nature of medical science and its restrictions and deformations in the capitalist mode of production, can be seen as forming a materialist basis for a theory of disability as oppression. It is the general failure of the Left to make such connections between capitalism and impairment which accounts for the fact that "no group on the 'revolutionary Left' . . . takes disablement seriously" (Sutherland, 1981:17). But Sutherland takes the discussion no further in his reliance on the 'naturalistic' view that "disablement is not merely the physical state of a small minority of people. It is the normal condition of humanity" (ibid., 18) since such a view separates some abstract 'human condition' from the social and historical conditions of its production. It cannot answer the question, why, if disablement is the 'normal condition of humanity' are only some members of the human race accorded the label 'disabled'?

COMMON FEATURES OF DISADVANTAGE

A characteristic of the literature of racial and sexual oppression is that it identifies certain generally common features of economic social and psychological disadvantage suffered by members of the oppressed group. The nature and extent of these disadvantages is by no means uniform or constant between groups or within groups over time, and can only be adequately described after detailed empirical investigation. Considerable literature exists to indicate the material disadvantages suffered by disabled people. To take only one recent example, Townsend (1979) produces a picture of low pay, longer hours, worse working conditions and housing, coupled with a higher likelihood of unemployment. For the purposes of this paper I shall assume this

study's findings as typical, reliable and valid, and explore this dimension no further. In addition to material and economic disadvantage, another extensive - body of work, of which perhaps the most famous example is still Goffman's

Stigma (Goffman, 1963), documents social and psychological disadvantage from what is explicitly or implicitly an Interactionist perspective. From the point of view of a theory of disability as oppression such studies are important in that they can be viewed as identifying and describing the social mechanisms by which the conditions described by social accountants such as Townsend are produced and reproduced. Care must be taken in 'translation', since a common feature of such studies is the assumed inevitability or 'rightness' of what is described. However, taken together and adequately re-interpreted such studies can form an important element in the development of a theory of disability as oppression. For example, Katz et al. (1979, 506) found that "Identical behaviours have different social meanings when produced by a normal and by a disabled person. The pleasant competent 'wheelchair bound' group leader aroused anger and got less help because she appeared to violate the stereotyped stigma role requirement which seems to require the disabled person to suffer and be inadequate. When the confederate in the wheelchair was caustic and hostile, this seemed to confirm social expectations and subjects were willing to offer more help."

In commenting on such examples we should endeavour to map out key features of the stereotype of the disabled person which a particular social formation produces and acts towards real disabled people in terms of. Our objective should be the explication of the material conditions which generate such stereotypes, not the mere description found in Interactionist approaches and empiricist psychology.

One key aspect of this stereotype in modern Britain is that whilst his/her 'primary identity' (Shearer, 1981, 23) resides in disability, the legitimacy and value of this identity is simultaneously denied. Whether perceived as 'tragic' or 'brave' a total identity of the person and the disability is assumed-but at the same time the disabled state is taken for granted as necessarily illegitimate to the extent that:

A crude and obtrusive imitation of a 'normal' body is held to be preferable to an elegant and efficient tool that makes no pretence of being anything other than what it is. (Sutherland, 1981: 75)

And

There's a tremendous emphasis on a child who's had polio or whatever to walk.... It's like standing up is considered infinitely better than sitting down, even if you're standing by standing in a total frame that weighs a ton, that you can't move in, which hurts and takes hours to get on and off and looks ugly. It's assumed that

that is what you want and that that's what is best for you. (ibid., 73)

The importance of the body in modern western society has been noted, for example in feminist literature and in considerations of youth culture, although any systematic sociological study has until recently been absent (Turner, 1984). For disabled people the body is the site of oppression, both in form, and in what is done with it. The prohibitions upon deaf children signing to each other as "something evil, like wanking-things you do with your hands that you're not supposed to" (Sutherland, 1981: 56) are the mirror image of the unrealisable ideals of physical perfection and competence constantly presented in the media and in conventional sporting and recreational material. But perhaps more significant than the requirements and prohibitions on what you do with your body as a disabled person are the things that are done to it. These 'rapes' and 'carrying off into slavery' correspond for disabled people to the more publicised features of sexual and racial oppression, and are often perpetuated in everyday life by the actions and the gaze of 'normal' people.

Interactionist studies, because of their failure to link interpersonal relations with the material base upon which interactions take place, can never proceed beyond the level of a descriptive and implicitly justificatory account. Impairment, taken as a given 'natural' property rather than a social product ultimately 'explains' discrimination and disadvantage for such analyses via appeal to some social mechanism parallel to the posited 'basic ethnocentrism' employed in some studies of race.

A further significant point to emerge from the consideration of such studies is the degree to which they produce and propagate a misidentification of who disabled people are. While the stereotype of disabled people, (as implied and in turn produced by the disability logo appearing on lavatory doors and motor cars) is of young people in wheelchairs as a result of MS, amputation, etc. This is far from the reality of the vast majority of disabled people.

The mean age of the 'young chronic sick' on Wood's (Wood, 1978) calculation was in 1978 50.3 years, only 9.8% disabled people being less than 45, a fact which has prompted a minor terminological amendment in the most recent literature, with 'young' renamed 'younger' (Royal College of Physicians, 1986b: 4).

Causes of impairment were also found to be at odds with the stereotype.

Causes of severe disability

Arthritis	31%	Amputation	1.5%
Stroke or Parkinson	15%	Paraplegia	1.3%
Cardio-respiratory	13%	Polio	0.7%
MS	2.8%		

(derived from Bury 1979, similar calculations can be made on the basis of data in Royal College of Physicians, 1986a).

There are a number of implications significant for a theory of disability as oppression which arise from this misidentification. Given the prevalent causes of impairment, the significance of the activities or inactivity of the medical agencies should not be underestimated, as it frequently is in certain sociological studies, and by those members of the general public who claim to view disabled people as 'just like everyone else'. Were the majority of disabled people subject to relatively stable conditions for which no medical interventions were appropriate such positions would be more tenable, but the predominant biological causes of impairment are conditions for which modern medicine at least lays claim to some ameliorative competence.

The stereotype addresses itself to people who, were they not disabled, would be expected to work--thus the Poor Law concerns with legitimacy described by Stone (1984) surface again, in public perception and concern if not in statistical reality (on Bury's calculation 57.9% of impaired adults were over 65 years of age). This group is also that identified in the Royal College of Physicians' report (1986a) as the one for whom provision is least adequate, and who are also identified in more anecdotal sources as subject to the most demeaning of 'tests' in seeking mobility allowances (*The Guardian*, letters, Aug. 1986).

This misidentification, while merely puzzling to Bury, can be seen as performing a number of important functions for the present social system. First, by directing attention away from impairment associated with ageing, it naturalises this aspect of the situation, and reduces the amount of perceived disability in society, so that disability appears as 'exceptional'. In reality about five and a half million, or one in ten people, in Britain today are disabled, approximately the same as the proportion of the workforce who are currently - suffering from unemployment.

Secondly, it focuses on that aspect of disability, namely its ability to effect potential workers, which is the primary concern of capitalism, for which the

'problem' of disability is why these people aren't productive, how to return them to productivity, and, if this is not seen as economically viable, how to handle their non-productivity in a manner which causes as little disruption as possible to the overriding imperative of capital accumulation and the maximisation of profits. Yet if the primary object of such theories is the 'young' disabled people, their effects reverberate far beyond their immediate subjects. One effect of the downgrading of the disabled state is to lead all people, including the 'young' disabled themselves, to deny their own suffering and to normalise their situation, thus maintaining the existing structures of social organisation and of work. Beyond this, society as a whole is affected, via the propagation of the work ethic and notions of normalcy implicitly contained in such theories. At this level there is a parallel with the argument (Brittan and Maynard, 1984) that racial and sexual oppression are integrally connected to masculine power in the notion of masculinity as mastery over nature. The points raised by Hunt (1966:146), who argues that disabled people challenge the prevailing norms of society in five main ways, "as unfortunate, useless, different, oppressed and sick", indicate how the mode of being of disabled people can be seen as constituting a paradigmatic negation of masculinity as thus conceived.

As in the cases of women and black people, oppressive theories of disability systematically distort and stereotype the identities of their putative subjects, restricting their full humanity by constituting them only in their 'problem' aspects. The more fashionable but equally unacceptable liberal reaction to this view is to deny all differences-similar to the assimilationist perspective in race relations, and thus similarly devaluing and denying the authenticity of an impaired person's experience, dissolving real problems in the soup of 'attitude change'. Both these viewpoints contain the explicit or tacit assumption that 'impairment' is a universally acceptable and primary explanatory factor. This can be seen particularly in the 'mourning' theories criticised by Oliver (1983), and reaches its most refined and nonsensical expression in such pronouncements as "he had the required toughness of mind-despite, or perhaps because of, legs crippled by polio" (Heren, 1984).

As with racism and sexism, a theory of disability as oppression must at some point face the question of who benefits from oppression. Whilst certain individuals and groups can be seen to accrue short-term advantage (a consideration of the manufacture, supply and fitting of artificial limbs in Britain today provides graphic examples of this) the main and consistent beneficiary must be identified as the present social order, or, more accurately, capitalism in a particular historical and national form. These latter distinctions are important ones, if we are to understand variations in policy and attitudes between nations and over time (Mitchell, 1985).

I have largely argued from analogy and through criticism of extant theoretical perspectives on disability. But this analogy has, I hope been a sustained one, and the criticisms have not been random. Taken together they imply a number of things about what an alternative theory, a theory of disability as oppression, will be concerned with and what it will look like, in contrast to oppressive theories. In conclusion I will try to make these points more explicit.

Some of the general effects of the oppression of disabled people are as follows.

- (1) It discourages individuals from trying to take up the 'privileges', to use Stone's (Stone, 1984) somewhat curious term, of disability and thus exempt themselves from the work process.
- (2) Because of negative stereotypes and material disadvantages connected to disability it encourages people, where possible, to normalise suffering and disease so as not to include themselves in a despised and disadvantaged sub-group.
- (3) It helps to constitute part of a passive 'sub-class' of welfare recipients (Leonard, 1984) which serves as a powerful warning against falling off the achievement ladder.
- (4) By presenting disadvantage as the consequence of a naturalised 'impairment' it legitimises the failure of welfare facilities and the distribution system in general to provide for social need, that is, it interprets the effects of social maldistribution as the consequence of individual deficiency.

In contrast to this, a theory of disability as oppression will attempt to flesh out the claim that historically specific categories of the 'disabled people' were constituted as a product of the development of capitalism, and its concern with the compulsion to work. This remained until the late nineteenth century largely the task of legal agencies, but the rise of scientific medicine resulted in . the transfer of policing from legal to medical authorities. While this clearly led to certain transformations in the situation of disabled people, medical ideology too devalues the impaired modes of being, at the same time as it naturalises the causes of impairment.

A theory of disability as oppression, then,

- (1) recognises and, in the present context, emphasises the social origins of impairment;
- (2) recognises and opposes the social, financial, environmental and psychological disadvantages inflicted on impaired people;

- (3) sees both (1) and (2) as historical products, not as the results of nature, human or otherwise;
- (4) asserts the value of disabled modes of living, at the same time as it condemns the social production of impairment;
- (5) is inevitably a political perspective, in that it involves the defence and transformation, both material and ideological, of state health and welfare provision as an essential condition of transforming the lives of the vast majority of disabled people.

While the political implications of such an analysis are apparent, the conceptual consequences are also profound, since such a notion of disability as oppression allows us to organise together into a coherent conceptual whole heretofore isolated and disparate area of social research, and potentially to correct the results of such theoretical myopia.

In summary, to usefully apply the notion of oppression to the complex of impairment, disability and handicap involves the development of a theory which connects together the common features of economic, social and psychological disadvantage with an understanding of the material basis of these disadvantages and the ideologies which propagate and reproduce them. Only such an account, specific and systematic, can move discussion beyond the level that it has reached so far, by bringing to bear the tools of today's social science, rather than those of the day before yesterday.

ACKNOWLEDGEMENTS

I would like to thank Sue Abberley, Caroline Freeman, Dee Northover and Christine Webb for their various contributions to the genesis of this paper.

REFERENCES

- ARTHRITIS AND RHEUMATISM COUNCIL (N.D.) Arthritis Research: the way ahead (London, ARC).
- BARKER, R.G. (1948) The social psychology of physical disability, *Journal of Social Issues*, 4(4), pp. 28-42.
- BARRETT, M. (1981) *Women's Oppression Today* (London, Verso).
- BATTYE, L. (1966) The Chatterley syndrome, in: HUNT, op. cit.
- BOTTOMORE, T. (Ed) (1983) *A Dictionary of Marxist Thought* (Oxford, Blackwell)
- BRITISH LEAGUE AGAINST RHEUMATISM (1977) *Rheumatism: the price we pay* (London, BLAR).

- BRITTAN, A. & MAYNARD, M. (1984) *Sexism, Racism and Oppression* (Oxford, Blackwell).
- BURY, M.R. (1979) Disablement in society, *International Journal of Rehabilitative Research*, 2, pp. 33-40.
- CAMPLING, J. (Ed.) (1981) *Images of Ourselves* (London, Routledge & Kegan Paul).
- CHESLER, M.A. (1965) Ethnocentrism and attitudes towards the physically disabled, *Journal of Personality and Social Psychology*, 2, pp. 877-82.
- COMMITTEE ON CHILD HEALTH SERVICES (1976) *Fit for the Future, Vol. 1* (London, HMSO).
- CONFEDERATION OF INDIAN ORGANISATIONS (U.K.) (1986) *Double Bind-to be disabled and Asian* (London, CIO).
- DARTINGTON, T., MILLER, E. & GWYNNE, G. (1981) *A Life Together* (London, Tavistock).
- DAVEY, A. (1983) *Learning to be Prejudiced* (London, Edward Arnold).
- DAVIE, R. et al. (1972) *From Birth to Seven* (London, Longman). DAVIS, F (1961) Deviance & disavowal, *Social Problems*, 9.
- EISENSTEIN, Z. (1979) Developing a theory of capitalist patriarchy and socialist feminism, in: *Capitalist Patriarchy and Socialist Feminism* (New York, Monthly Review Press).
- FRY, E. (1986) *An Equal Chance for Disabled People? -A study of discrimination in employment* (London, The Spastics Society). GOFFMAN, E. (1963) *Stigma* (New Jersey, Prentice-Hall).
- HANDEL, A.F (1960) Community attitudes and adjustment to disability, *Outlook for the Blind*, No. 54, p. 363.
- HEREN, L. (1984) *The Observer*, London, 30 December.
- HUNT, P (1966) A critical condition, in: P HUNT (Ed.) (1966) *Stigma*, pp. 145. 159 (London, Chapman).
- KAUFERT, J. & KAUFERT, E (1984) Methodological and conceptual issues in measuring the impact of longterm disability, *Social Science and Medicine*, 19, pp. 609-619.
- KINNERSLEY, P (1973) *The Hazards of Work* (London, Pluto Press).
- LEONARD, P (1984) *Personality and Ideology*, Ch. 8 (Basingstoke, Macmillan).
- MITCHELL, P (1985) *A Comparison of Social Provision For People with Disabilities in the Netherlands and the U.K.* (London, RADAR).
- MULLER, M. (1982) *The Health of Nations* (London, Faber).
- NAVARRO, V (1982) The labour process and health international, *Journal of Health Services*, 12, pp. 5-29.
- NEW SOCIETY (1985) Findings, 7 June.
- NICHOLS T. (1986) Industrial injuries in British manufacturing in the 1980s, *Sociological Review*, 34, pp. 290-306.

- OLIVER, M. (1983) *Social Work with Disabled People* (Basingstoke, Macmillan).
- OLIVER, M. (1986) Social policy and disability: some theoretical issues, *Disability, Handicap and Society*, 1, pp. 5-18.
- PEARSON COMMISSION REPORT (1978) Vols 1 and 2 (London, HMSO).
- RICHARDSON, S.W. & GREEN, A. (1971) When is black beautiful? Coloured and white children's reaction to skin colour, *British Journal of Educational Psychology*, 41, pp. 62-9.
- ROYAL COLLEGE OF PHYSICIANS OF LONDON (1986a) *Physical Disability in 1996 and Beyond* (London, RCP).
- ROYAL COLLEGE OF PHYSICIANS OF LONDON (1986b) *The Young Disabled Adult* (London, RCP).
- SADGROVE, J. (1985) I deserve this cigarette, *New Statesman*, 109(2830), 14 June, pp. 9-11.
- SHEARER, A. (1981) *Disability: whose handicap?* (Oxford, Blackwell).
- SHIRLEY, O. (Ed.) (1983) *A Cry for Health poverty and disability in the Third World* (Frome, Third World Group & AHRTAG).
- STONE, D. (1984) *The Disabled State* (Basingstoke, Macmillan).
- SUTHERLAND, A. (1981) *Disabled We Stand* (London, Souvenir Press).
- THUNHURST, C. (1982) *It Makes You Sick-the politics of the NHS* (London, Pluto Press).
- TOWNSEND, P (1979) *Poverty in the United Kingdom* (London, Penguin).
- TURNER, B.S. (1984) *The Body & Society* (Oxford, Blackwell).
- WOOD, PH.N. (1978) Size of the problem and causes of chronic sickness in the young, *Journal of the Royal Society of Medicine*, 71, PV 437-441.