

Disability: A Sociological Phenomenon Ignored by Sociologists

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Abstract.

This paper demonstrates that hitherto sociological analyses of disability have been theoretically and methodologically inadequate. The main reason for this is that sociology, in common with the other major contemporary disciplines, has accepted almost without question the legitimacy of the individualistic, biomedical approach to disability. It is argued that this partial and essentially 'non-disabled' reading of the phenomenon has succeeded in precluding a meaningful evaluation of the economic, political and cultural forces which created and continue to create disability in modern society. Thus, the discipline as a whole has contributed significantly to the continued marginalisation of the disabled population. Moreover, by focusing on the development of the international disabled people's movement and the work of disabled writers it is suggested that disability is an issue as central to mainstream sociological discourse and analysis as class, gender, race and sexuality.

Introduction.

Recently, a number of sociologists working in the general area of medical sociology and chronic illness have expressed concern over the growing importance of the 'social oppression theory' of disability, associated research methodologies, and their implications for doing research in the 'chronic illness and disability fields' (Bury, 1992). Whilst these writers feel the need to 'positively debate' these developments the basis of their concern is similar to that expressed by Hammersley with respect to some aspects of feminist research, i.e. the tendency to 'privilege experience over sociological research methodology' (Hammersley, 1992). In short, it is perceived as a threat, firstly, to 'non-disabled' researchers doing disability research, secondly, to the traditional role of the sociologist giving 'voice to the voiceless' -in this case 'older' disabled people whose interests are said to be poorly served by 'social oppression theory', and, thirdly, to the 'independence' of sociological activities within the 'medical sociology world'

In this paper it will be argued that in the general area of disability research 'experience' should take precedence over 'sociological' research methodologies, simply because hitherto 'non-disabled' researchers have consistently failed to address the question of disability as perceived by disabled people whether young or old. It will also be proposed that within the context of medical sociology, sociological 'independence' has been conspicuous by its absence due to medical sociologists almost slavish adherence to the traditional individualistic medical view of disability or 'personal tragedy theory' (Oliver, 1986; 1990). Finally, it will be shown that disability can no longer be considered solely as a medical problem affecting only a minority of the population but must be perceived as a civil rights issue as central to mainstream sociological discourse and analysis as class, gender, race and sexuality.

Sociological Accounts of Disability

Functionalist Accounts

Almost without exception the overwhelming bulk of sociological writing on disability is rooted in the work of Parsons and his analysis of sickness related behaviour. This is because the Parsonian paradigm has been principally responsible for two distinct, but interdependent, approaches which have implicitly or explicitly influenced all subsequent analyses. They are the relevance of the 'sick role' in relation to disability and its association with social deviance, and the notion of health as adaptation (Bury 1982).

Briefly, Parsons' model suggests that at the onset of illness 'sick' people should adopt the sick role. Rooted in the assumption that illness and disease impede both physiological and psychological abilities, 'sick' individuals are automatically relieved of all normal expectations and responsibilities. Generally considered unaccountable for their condition they are not expected to recover through their own volition. They are encouraged to view their present situation as 'abhorrent and undesirable', and, in order to regain their former status, are expected to seek help from professional medical experts (Parsons, 1951).

Parsons' model assumes that regardless of the nature of the condition or the socio/economic factors involved everyone will behave in exactly the same way. It pays little heed to subjective interpretation and articulates only the views of the representatives of society credited with the responsibility for recovery, i.e. the medical profession.

It does not accommodate the sick role variation (Twaddle, 1969) nor the distinction between illness and impairment (Gordon, 1966; Sieglar and Osmond 1974).

Occupation of the sick role is intended to be temporary. But the same assumptions are applied to people with impairments. The 'impaired role', for example, is ascribed to an individual whose condition is unlikely to change and who is unable or unwilling to meet the first prerequisite of the sick role - to 'get well' as quickly as possible. Occupants of this construct are said to have abandoned the idea of recovery altogether and accepted dependency. Signifying a loss of 'full human status' the impaired role does 'not require the exertions of co-operating with medical treatment and trying to regain one's health, but the price for this is a kind of second class citizenship' (Sieglar and Osmond, 1974, p. 116).

A further variation on this train of thought is the 'rehabilitation role' as articulated by Safilios-Rothschild (1970). This model suggests that once a person with an impairment becomes aware of their condition they must accept it and learn how to live with it. This is achieved, it is argued, through the maximisation of existing abilities. Within this frame of reference individuals with impairments are obligated to assume as many 'normal' functions as quickly as possible. They are not exempt from social expectations or responsibilities but must adapt accordingly. Additionally, they should co-operate with professionals and innovate and ameliorate new methods of rehabilitation.

Clearly, the locus of responsibility rests squarely on the shoulders of the person with an impairment. They are dependent upon the rehabilitation professionals for at least two specific functions, first, the initiation of rehabilitation

programmes designed to return individuals with impairments to 'normality', and, second, assistance in the psychological accommodation of a 'disabled' identity. The process of cognitive adjustment to impairment is usually presented as a series of psychological stages such as 'shock', 'denial', 'anger' and 'depression'. Movement is sequential and generally seen as only one way. Passage through each stage is determined by an acceptable time frame according to professionally agreed criteria (Albrecht, 1976).

Apart from the fact that there is substantial evidence questioning the empirical validity of these theories (Silver and Wortman, 1980) they can be criticised on at least three different levels. First, they are essentially determinist; behaviour is only viewed positively if it is commensurate with professionals' perceptions of reality. Second, they ignore extraneous economic, political and social factors. Third, they undermine and deny subjective interpretations of impairment from the perspective of the person concerned. In sum, they are the product of the 'psychological imagination' constructed upon a bed-rock of 'non-disabled' assumptions of what it is like to experience impairment (Oliver, 1983). The realisation of impairment is presumed to involve some form of loss or 'personal tragedy'. Thus, this individualistic medical approach can best be understood as 'personal tragedy theory' (Oliver, 1986).

One important factor explaining the continued ideological hegemony of 'personal tragedy theory' is its professional expediency, both at the individual and at the structural levels. If individuals fail to achieve the anticipated professionally determined rehabilitation goals then this failure can be explained with reference to the disabled person's perceived inadequacy - whether it be physically or intellectually based or both. The 'expert' is exonerated from responsibility, professional integrity remains intact, traditional wisdom and values are not questioned, and the existing social order remains unchallenged (Barnes, 1990).

Disability as Social Deviance

The relationship between disability and deviance can be understood with reference to the freedom from social obligations and responsibilities explicit in the sick role construct and subsequent derivatives. and in the negative view of impairment prevalent in industrial and post industrial societies. Because such societies are founded upon liberal ideals of individual responsibility, competition and paid employment, any positive association with impairment, such as freedom from social obligations and responsibilities, must be discouraged - especially as they may appear attractive to those already economically and socially disadvantaged by class, gender, race or sexual preference.

The analysis of social reaction toward disadvantaged minority groups such as people with impairments was central for sociologists working within the traditions of symbolic interactionism during the 1960s. With their emphasis upon meaning, identity and the process of labelling they explored the relationship between disablement and socially proscribed behaviour. Initially, sociologists working within this perspective were interested in crime and drug addiction but after substantial ethnographic research turned their attention toward the mechanisms of deviance creation and the labelling process (Becker, 1963). Lemert (1962) made the distinction between 'primary' and 'secondary' deviance; the former having only marginal implications for the individual concerned and the latter relating to the ascription by others of a socially devalued status and identity. Secondary deviance becomes a central facet of existence for those so labelled, 'altering psychic structure' producing specialised social roles for self management.

Goffman (1963) developed the idea further with his use of the concept 'stigma' a term, he claimed, used traditionally to refer to a mark or blemish denoting 'moral inferiority' necessitating avoidance by the rest of society. He suggested that the 'stigmatised' such as 'the dwarf, the blind man, the disfigured. ... and the ex-mental patient' are generally viewed as not quite human. For Goffman, the application of stigma is the outcome of situational considerations and social interactions between the 'normal' and the 'abnormal'.

Clearly, Goffman's use of the term 'stigma' is based upon perceptions of the oppressor rather than those of the oppressed. Derived from the Greek practice of marking slaves, the application of stigma is an issue of exploitation and oppression rather than avoidance; slave masters did not avoid their slaves they used and abused them for their most personal, intimate and sexual needs. In the modern context Goffman takes as given the imposed segregation, passivity and inferior status of stigmatised individuals and groups including disabled people without seriously addressing questions of causality (Finkelstein, 1980).

Impairment. Disability and Handicap

Throughout this period other writers stuck to a more conventional approach. Haber and Smith (1971), for example, argued that we should focus rather on the elaboration of behavioural alternatives within existing role relationships rather than the proliferation of 'specialised role repertoires'. In this way the behaviour of disabled people is effectively 'normalised' as adaptation. But normalisation for most sociologists has meant that disability can be subsumed within the category 'chronic illness' and, with few exceptions, this is where it has remained for the last twenty five years.

Research by Jeffreys and others in the first national study of chronic illness and disability in Britain produced functional assessments of impairment based on the threefold distinction between impairment, disability and handicap (Buckle, 1971; Harris, 1971). Subsequent work within the international context by Wood and Badley (1978) and Wood (1981) resulted in the adoption of this typology by the World Health Organisation (WHO); it has dominated sociological analyses and social policy research ever since.

Inextricably linked to concepts of illness and disease the WHO approach conserves the notion of 'impairment' as 'loss or abnormality of psychological, physiological or anatomical structure or function', 'disability' as the inability to perform an activity.. considered 'normal for a human being, resulting from an impairment' and 'handicap' as inability to perform a normal social role 'resulting from an impairment or disability' (Wood and Badley, 1978; Wood, 1981).

The first major problem with this approach is that physical and psychological normality is not easily defined. Definitions are dependent upon temporal, cultural and situational factors, and the failure to recognise this in a classification system supposed to have universal currency is especially serious (OECD., 1987). Further, similar criticisms can be applied to the schema as used by the Government sponsored OPCS (Office of Populations Censuses and Surveys) (OPCS) disability survey in Britain during the 1980s (see Martin et al. 1988; 1989). It too failed to acknowledge the influence of sub-culture, gender or ethnicity on notions of normality (Oliver, 1990).

Second, the human being is perceived as flexible and alterable while the physical and social environment are assumed to be fixed and unalterable. This clearly flies in the face of reality since historically human beings have always moulded the environment to suit their needs rather than the other way round (Barnes, 1991). Third, since psychological and physical impairments are presented as the cause of disability and handicap, it follows that they should be cured by psychological or medical intervention. People with impairments become objects to be treated, changed, improved and made 'normal'(OECD, 1987).

While medical intervention to treat illness and disease may be quite appropriate, it is often quite inappropriate for treating disability. Yet doctors and rehabilitation professionals continually recommend medical treatments and practices even though they will not necessarily improve the quality of life for the person concerned. 'Indeed, questions about the quality of life have sometimes been portrayed as an intrusion upon the medical equation' (Brisenden, 1986, p.176).

Fourthly, because it is assumed that people with impairments must adapt to a hostile environment they are subjected to all kinds of emotional pressure in the process of adaptation.

Those who succeed are sanctified and held up as exemplars of individual will and effort, while the majority who do not are referred to as passive, apathetic or worse (Reiser and Mason, 1990). This has obvious negative psychological implications for disabled individuals which can and often does compound impairment (Barnes, 1990).

Fifth, these definitions tend to present impairment, disability and handicap as static states. Apart from the fact that this approach is inaccurate (Oliver, 1990) it creates artificial distinctions and barriers between disabled people and the rest of society (Zola, 1982). In short, these definitions not only help to create and perpetuate oppression in all its forms but waste valuable resources on a grand scale (Davis, 1986).

Indeed, the fact that disabled people were excluded from participating in a meaningful way from the process of constructing these schemes is a waste of the most valuable resource of all, i.e. the perceptions of people who experience 'chronic illness' or disability daily. It is not surprising then that they are rejected by a growing number of disabled people and their organizations, including the British Council of Organisations of Disabled People (BCODP) and Disabled Peoples International (DPI) (see below).

Finally, in terms of research this approach to disability can have significant oppressive consequences for disabled individuals. This can be seen clearly with reference to the methodology used in the recent OPCS survey mentioned above. A comparison of two sets of questions relating to the same topics illustrate the point. The first (Table 1) is taken from the interview schedule used by the OPCS researchers and the second (Table 2) is constructed on the basis of a social definition.

Table 1: Survey of Disabled Adults -OPCS, 1988.

- * Can T'OU tell me what is wrong with you?
- * What complaint causes your difficulty in holding, gripping or turning things?
- * Have you attended a special school because of a long term health problem or disability?
- * Does your health problem/disability prevent you from going out as often or as far as you would like?

* Does your health problem/disability effect your work in any way at present?

These questions effectively locate causality of the functional problems experienced by disabled people at the subjective level. They could have been reformulated as follows.

Table 2: Alternative Questions - Oliver, 1990.

* Can you tell me what is wrong with society?

* What defects in the design of everyday equipment like jars, bottles and tins causes you difficulty in holding, gripping or turning them?

* Have you attended a special school because of your education authorities policy of sending people with your impairment to such places?

* What are the environmental constraints which make it difficult for you to get about in your immediate neighbourhood?

* Do you have problems at work because of the physical environment or the attitudes of others?

According to OPCS 2231 isolated individual disabled people were interviewed. They were visited in their homes by 'official', 'expert' researchers. They were asked a specified sequence of formal questions, of which they had no prior knowledge, and they had no opportunity to clarify or discuss their responses. Given the nature of the questions and the manner in which they were delivered it is hardly surprising that respondents accepted the view that their health problems are the cause of any deprivations experienced. It is in this sense that the interview process is oppressive, reinforcing onto isolated, individuals with impairments the idea that the problems they experience in every day life are a direct outcome of subjective inadequacies or functional limitations and not the organisation of society (Oliver, 1990).

Yet despite all this the bulk of sociological research, especially in the United Kingdom, has hitherto adhered almost religiously to this person centred medical approach to disability. Recent qualitative work, for example, has focused on the consequences of illness and the management of symptoms (Anderson and Bury, 1988; Bury, 1982), the role of the medical profession and medical treatments (Fitzpatrick et al. , 1987; Jobling, 1990; Robinson, 1988), the impact on self and identity (Scrambler, 1989) and its meaning in terms of social interaction (Gerhardt, 1989).

It has only recently been acknowledged by medical sociologists that the discipline's preoccupation with the biomedical perspective has precluded analysis of wider structural concerns which create disability (Bury, 1991; 1992). Additionally, it is a point made by Jenkins in a recent paper drawing attention to

the relationship between disability and social class (Jenkins, 1991) and Albrecht in his evaluation of the social creation of disability by the American rehabilitation industry which he contends is a 'new' perspective on the study of disability (Albrecht, 1992).

What is truly remarkable about all this is that this recent shift of emphasis by these sociologists has occurred almost exclusively without reference to the growing international disabled people's movement, the work of disabled writers, and their increasing impact on social policy and social research outside sociology.

The Disabled People's Movement and Changing Perceptions of Disability.

The Disabled People's Movement.

In Britain, the roots of the disabled people's movement can be traced back to the last century with the formation in the 1890s of the British Deaf Association and the National League of the Blind (Pagel, 1988). However, the movement really took hold during the 1960s with the struggle for autonomy and independence by a group of disabled residents in residential institutions (Finkelstein, 1991) and the setting up of the Disablement Income Group (DIG) an organisation focusing on the poverty associated with disability which has consistently lobbied Parliament for improved disability benefits since its inception - by two disabled women in 1965. The spread of disability organisations in the ensuing decade and their failure to secure a comprehensive disability income led to the formation of an umbrella organisation known as the Disability Alliance (DA) in 1975.

In America, the Independent Living Movement (ILM) emerged out of the campus culture of the late 1960s. Self help among disabled students achieved greater visibility' and momentum with the creation of the first Centre for Independent Living (CIL) in Berkeley, California in 1972. Managed and run by disabled students the Berkeley CIL provided a wide range of related services such as peer counselling, advocacy services, transport, personal assistance services, and training in independent living skills and community based living (De Jong, 1979). In the following years similar CILs and organisations sprang up throughout the United States, Canada and Europe (Dreidger, 1989; Evans, 1993).

But the American ILM's activities were not confined to setting up CILs. Allied organisations such as the American Coalition of Citizens with Disabilities (ACCD) were instrumental in monitoring federal legislation affecting disabled people. The ACCD also helped to organise the nationwide civil disobedience

campaign which goaded the US Department of Health, Education and Welfare to promulgate regulations implementing Section 504 of the American 1973 Rehabilitation Act; legislation which attempted to outlaw unfair discrimination against disabled people. Subsequent action by the ILM has led to the introduction of the most comprehensive anti-discrimination policy yet introduced; the 1990 Americans with Disabilities Act (West, 1991).

In Britain the DIG and the DA concerned themselves mainly with the financial needs of disabled people due mainly to the influence of non-disabled academics and professionals. It is an approach rooted in the traditional medical view that disabled people are economically and socially dependent on the non-disabled community. It is an approach which perpetuates this myth by ignoring the root causes of disabled people's dependence, i.e. their widespread and systematic exclusion from the economic and social life of the community (UPIAS, 1976). Organisations controlled and run by disabled people have favoured a more radical approach commensurate with that of the American ILM (Finkelstein, 1991; Oliver, 1990).

Since the mid 1970s organisations of disabled people such as the Union of Physically Impaired Against Segregation (UPIAS), formed in 1974; the Liberation Network, who functioned mainly through the publication of a magazine titled 'In From The Cold' between 1979 and 1983; and the early disabled women's movement in the form of 'Sisters Against Disability', have all shared the same basic goals; securing equal rights for disabled people, and the removal of negative discrimination in all its forms (Davis, 1993). These goals were later adopted by the ten organisations which came together in 1981 to form the British Council of Organisations of Disabled People (BCODP). A member of Disabled People's International (OPI) from the outset the BCODP now includes 90 organizations representing over 300,000 disabled individuals.

Self organisation and developments at the international level precipitated a significant intensification of the campaign for equal rights during the 1980s in Britain. In 1985 the Voluntary Organisations for Anti-Discrimination Legislation (VOADL) was established. This event is important because it signalled the decisive coming together of organisations of disabled people, like the BCODP, along with a number of the traditional organisations for disabled people controlled and run by non-disabled people such as the Royal Association for Disablement And Rehabilitation (RADAR) and the Spastics Society. VOADL's existence is a clear indication of the growing strength of the disabled people's movement in Britain; hitherto several organisations for disabled people had advised British governments that discrimination was not a problem and anti-discrimination legislation unnecessary. Nevertheless, in spite of this apparent unity of purpose there remains crucial differences between the

inherently paternalistic approach of these organisations and the emancipatory philosophy of the BCODP (Oliver and Barnes, 1991).

As a consequence of this campaign, since 1982 there has been eleven unsuccessful attempts to introduce a comprehensive anti-discrimination mandate for disabled people in Britain similar to that already in place in other societies such as Australia, Canada and the USA (Bynoe et al., 1991). The call for legislation is supported by Britain's two main opposition parties and although the present Government has hitherto declined to introduce such a Bill it now recognises that institutional discrimination against disabled people is a major problem (Hansard, 1992a; 1992b and 1993).

Besides being at the centre of the campaign for disabled people's rights the BCODP and its member organisations have produced a range of policy initiatives which have transformed the lives of many disabled people in Britain. These include policies which enable disabled people throw off the shackles of unnecessary bureaucratic regulation and control; earn a living rather than live off the state; achieve personal autonomy to a degree comparable to that of non-disabled peers; and to expand their role as consumers. These initiatives have firmly established the BCODP as the only truly representative voice of disabled people in Britain (Barnes, 1991, 1993 ; Davis, 1993; Hasler, 1991, 1993; Oliver, 1990).

The BCODP's success has also prompted an increasing number of disabled individuals to adopt a collective disabled identity' and take a more direct approach to political participation. Much of the inspiration for this radicalisation stems from America, in particular the strategies adopted by the Civil Rights Movement and the ILM. In the USA the Civil Rights movement of the 1960s had an enormous influence on the securing of disabled people's rights, and the manner by which those rights were secured. When traditional legal channels were exhausted disabled Americans employed other techniques of social protest including organised boycotts, sit ins and street demonstrations (Oliver, 1990).

Initially, the excessive paternalism of the welfare state and the absence of a strong British Civil Rights tradition caused disabled people in Britain to be cautious in their choice of tactics. But this situation has changed dramatically over the last few years. Despite the enormity of the environmental barriers confronting them they have taken to the streets in increasingly large numbers to protest against institutional discrimination in all its forms. Since the Rights not Charity march of July 1988 there has been a growing number of demonstrations and civil disobedience campaigns by disabled people and their supporters up and down the country against a range of issues including: inaccessible transport, an inaccessible environment, pedestrianisation, the exploitation of disabled

people by television companies and charities, and the poverty which accompanies impairment. In order to focus the public's attention on these and other injustices disabled people are now risking public ridicule, arrest and even imprisonment (Barnes, 1991; Davis, 1993; Hasler, 1991, 1993; Oliver, 1990; GMCDP, 1992).

Changing Perceptions of Disability.

Within the context of these developments disabled writers, both in Britain and in America, began to challenge the orthodox wisdom and traditional individualistic, essentially medical approaches to disability and rehabilitation. In Britain, in the early 1960s the disabled activist Paul Hunt put together twelve essays on the experience of disability emphasizing the social nature of the phenomenon entitled 'Stigma; The Experience of Disability' (1966). In America, Robert Scott (1970) questioned the logic of the creation of social 'deviants' in the interactions between rehabilitation professionals and people with impairments. His study of 'blindness workers' describes how they make 'blind men out of people who cannot see' by the imposition of blindness related behaviour and attitudes which conform to experts' perceptions of blind people. For Scott this represents a form of enforced socialisation in which the person with the impairment is coerced into accepting a dependent subordinate role, concomitant with a non-disabled view of disability.

More in keeping with the work of Merton (1957) rather than Parsons or Becker, Rinif Anspach (1979) developed a four dimensional model which he believed typified the modes of adaptation used by people with impairments in response to societal reactions to disability. The first, the 'normaliser' refers to disabled individuals who accept and concur with societal perceptions of impairment and seek acceptance at any price. The second is 'disassociation' where the individual adopts the wider cultural perceptions of disability but is unable to accept it with regard to themselves. Hence they avoid social contact as it reinforces negative self-concepts. The third, 'retreatism' is almost identical to Merton's concept. Consonant with negative perceptions of society and self, the individual rejects the wider cultural views of disability but has little or no self esteem. Withdrawal from all social activity is the preferred pattern of behaviour. The fourth, the author's obvious preference, is the 'political activist'. Individuals adopting this role reject conventional negative perceptions of disability, have a positive view of self, and work for change (Anspach, 1979).

Though orthodox in its construction, Anspach's typeology serves to highlight the radicalisation of the disabled population within American society during the late 1960s and early 70s. Also drawing on the collective experience of the ILM, Gerben De Jong (1979) challenged the validity of the traditional medical

approach to disability. He argued that environmental factors were at least as important as impairment related variables in assessments of dependence. For De Jong this essentially 'social model of disability' represented a paradigm shift in the celebrated tradition of Thomas Kuhn (1962), by which the current body of knowledge and thinking on disability would be rendered obsolete. While De Jong is critical of rehabilitation professionals and their functional definitions of impairment and disability he fails to provide an analysis of the structural factors which precipitated their development and application.

An attempt to resolve this problem can be found in the work of a non-disabled writer Deborah A. Stone (1984). For Stone, all societies function through a complex system of commodity distribution, the engine of which is labour. Since not everyone is able or willing to work, a second system of distribution comes into play; a system based on perceptions of need. She maintains that disability assessments are not made on medical or clinical grounds alone but on political considerations too. Thus, the disability category is a social construct. The medicalisation of disability is explained with reference to the accumulation of power by the medical profession and the state's need to restrict access to the state sponsored welfare system. However, Stone's 'socially constructed' conception of disability differs substantially from the 'socially created' view of disability favoured by many disabled writers in the United Kingdom.

The social constructionist view perceives the problem of disability situated within the minds of non-disabled people individually as prejudice, and collectively as the manifestation of hostile social attitudes and practices based upon negative assumptions of impairment. The social creationist view perceives the problem of disability as the outcome of the institutionalised practices of contemporary society (Oliver, 1990).

The theoretical foundations for the latter can be found in the work of the UPIAS in the mid 1970s. Having broken away from the Disability Alliance because of its domination by non-disabled academics and their uncritical acceptance of the traditional medical approach to disability they produced a two fold classification of disability. The purpose of which was to shift the basis of causality from the individual on to society and social organisations. Thus, impairment remains close to the medical model referring to 'lacking all or part of a limb, or having a defective limb, organism or mechanism of the body' but disability is 'the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of social activities' (UPIAS , 1976, pp. 3-4). Subsequently, the terminology has been modified to include all forms of impairment - sensory, intellectual and hidden - and these

definitions were adopted by the international disabled people's movement, the DPI and the BCODP following their formation in 1981.

An historical account of the social creation of disability can be found in the work of Finkelstein, a disabled clinical psychologist and a founder member of UPIAS. Utilising an essentially materialist evolutionary approach Finkelstein shows that, for Britain at least, history within the modern epoch can be divided into three distinct sequential phases. The first broadly corresponds to the feudal period immediately prior to industrialisation where economic activity consisted primarily of agrarian or cottage based activities - a mode of production which did not necessarily preclude disabled people from participation in the economic and social life of the community.

But in phase two - the nineteenth and first half of the twentieth centuries, a period of industrialisation, liberalism, the medical appropriation of the body, social darwinism and the Eugenics movement - disabled people were systematically excluded from the workplace on the grounds that they were unable to conform to what Foucault (1977) termed the 'disciplinary power of the factory'. They were segregated from mainstream economic and social life and incarcerated into a variety of institutions including special schools, asylums, workhouses and long stay hospitals created specifically for this purpose. The third phase, which is only just beginning, will see the eventual liberation of disabled people from societal oppression through the development and utilisation of technology', and the working together of disabled people and professionals toward commonly held goals (Finkelstein, 1980).

For Finkelstein disability is a paradox involving the disabled individual and the restrictions imposed upon them by society. Finkelstein's three stage model demonstrates how the paradox emerged during industrialisation. In phase one disabled people were dispersed throughout the community as part of the underclass. In phase two they were marked out for special treatment and segregated, and disability became a special category understood as individual impairment and social restriction.

Intended as a heuristic device rather than an accurate historical account Finkelstein's model focuses attention on the social nature of disability and the economic and political considerations which shaped contemporary attitudes toward impairment. For Finkelstein, the 'helper/helped relationship' plays a crucial role in shaping the consciousness of the individuals concerned. The rise of 'able bodied' assumptions in phase two represents a major transformation in which relations with disabled people were conducted. Personal tragedy theory is built into these relations. When non-disabled helpers assume the normal assumptions of the helper/helped relationship they inculcate the disabled person

with similar presumptions. Hence, disability is a particular form of social oppression or discrimination experienced by people with some form of impairment.

Throughout the 1980s there has been growing evidence, both qualitative and quantitative, of the extent of institutional discrimination against disabled people in all areas of British society, i.e. in education, the workplace, the welfare system, the environment, leisure and the media, and in politics (see, for example, Barnes, 1991; 1992; CORAD, 1982; Fry 1987; Graham et al., 1991; Oliver, 1985; Oliver and Barnes, 1991; Hevey, 1992; Sutherland, 1981; Reiser and Mason, 1990). Moreover, with few notable exceptions, examples include Barton and Tomlinson's work on special education (1981) and Lonsdale's analysis of disability and women (1992), the bulk of this research has been initiated and produced by disabled writers and/or disability organisations.

Other work has also clarified and explored the links between institutional discrimination against disabled people and other forms of social oppression such as racism, sexism, heterosexism and ageism, and the multiple oppression encountered by disabled women, disabled Black people, disabled Lesbians and disabled Gay men, and elderly disabled people (Abberley, 1987; Begum, 1990; Gillespie Sells, 1992; Macfarlane, 1991; Morris, 1991; Stuart, 1992; Zarb and Oliver, 1993). Furthermore, the disabled people's movement as a whole has, rightly, been conceptualised within the context of the newly emergent social movements associated with 'late capitalist society' (Oliver, 1990).

Moreover, in view of the alienating properties of traditional approaches to disability research, both for research subjects and for researchers (Oliver, 1991), a number of disabled and non disabled researchers have begun to work with disabled people's organisations to develop a new approach. What has become known as the 'emancipatory research paradigm' seeks to further the interests of research subjects rather than those of the researcher and/or those who control disability research production (Disability, Handicap and Society, 1992).

It is an approach which means researchers putting their skills at the disposal of disabled people and their organisations in order to generate research initiatives relevant to the disabled community rather than to the research establishment. Indeed, disabled people should be represented on all decision making bodies concerned with disability research production. Disability as a socio/political issue should take precedence over conventional biomedical approaches. Moreover, equal opportunities with respect to disabled women, disabled Black people, disabled Lesbians and disabled Gay men should be given due consideration throughout all disability research. Institutional discrimination against marginalised groups within the disabled community is not something

which can be 'added on' to disability research as an after thought. It also means that research methodologies must be adopted which yield the highest level of accountability to research subjects or to their advocates (Disability, Handicap and Society, 1992).

As disabled people and their organisations have shown disability can no longer be regarded as simply a medical problem solvable by medical intervention. It is an equal rights/opportunities issue as fundamental to contemporary society as class, race, gender and sexuality. Current estimates suggest that there are at least six and a half million disabled adults and children in the United Kingdom (Martin et al. , 1988), fifty million disabled people in Europe (Daunt, 1992) and over five hundred million world wide (UN, 1982). Clearly, disability is a phenomenon which mainstream sociology can no longer ignore.

Conclusion.

This paper has demonstrated that hitherto sociological analyses of disability have been theoretically and methodologically inadequate. The main reason for this is that sociology, in common with the other major contemporary disciplines, has accepted almost without question the legitimacy of the individualistic, biomedical approach to disability. Following the work of the early role theorists and interactionists - who never managed to move beyond the shadow of Parsons' analysis of sickness related behaviour - the field has been dominated by medical sociologists who have chosen to concentrate upon measurements of impairment and the experience of 'chronic illness' rather than the experience of disability as perceived by disabled people. Until very recently this partial and essentially 'non-disabled' reading of the phenomenon has succeeded in precluding a meaningful evaluation of the economic, political and cultural forces which created and continue to create disability in modern society. Thus the discipline as a whole has contributed significantly to the continued marginalisation of the disabled population.

However, this remarkable situation has been resolved by disabled people themselves in the form of the international disabled people's movement and a small but committed group of disabled and non-disabled researchers. In the face of formidable environmental and ideological opposition from a variety of sources they have transformed perceptions of disability by drawing upon disabled people's individual and collective experiences; something which sociology and the research establishment has hitherto consistently failed to do. The outcome of which is that disability is no longer considered simply a medical problem effecting only a minority of the population but is increasingly perceived as one of the major socio/political phenomena of our time with implications for society as a whole. Clearly, it is an issue which is as central to

mainstream sociological discourse and analysis as class, gender, race and sexuality. It is an indication of the discipline's intellectual stagnation and methodological decay over the last fifteen or so years that sociologists have only just begun to realise this.

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