

**Discrimination Against Disabled People  
(Causes, Meaning and Consequences)  
Or  
The Sociology of Disability**

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## 1. Introduction

'It is by means of the sociological imagination that men now hope to grasp what is going on in the world, and to understand what is happening in themselves as minute points of the intersections of biography and history within society'.

C. Wright Mills

Discriminatory action against the physically or cognitively less able in some form or other has been an integral part of almost every society throughout history. And although it is undoubtedly true that the more extreme forms of negative discrimination which were synonymous with earlier epochs, such as violent persecution and infanticide have largely disappeared, the fact remains that the quality of life experienced by the majority of handicapped people in modern society is considerably lower than that enjoyed by their able-bodied contemporaries. Moreover, it appears that as our society becomes evermore socially and technologically complex the numbers of people perceived as disabled is steadily increasing. Indeed one writer has estimated that there are over nine million handicapped people living in the British Isles (see chapter one) and there is little evidence to suggest that these figures are likely to decline in the foreseeable future.

Now the fact that the general standard of living experienced by this increasingly large section of the community is consistently lower than that of the majority indicates that the discrimination against the disabled in modern society is still a reality, and although the social effects of this phenomenon are less obvious than those associated with earlier more violent times they are none the less debilitating for those concerned. This essay is an attempt to understand the causes and effects of discrimination against disabled people.

Generally speaking, apart from the work of Erving Goffman and Fred Davis, relatively little has been written on the subject of disability within Sociology. While their work has highlighted the complexity of the process of social interaction between the handicapped and the able-bodied, both authors have been content to place the subject of disability alongside deviance and minority group membership as a social phenomenon. This I feel is a mistake - apart from the fact that deviance and deviant behaviour, and to some degree, minority group membership are generally associated with some elements of choice, freedom of action and morality, the same cannot be said of the disabled. They are as they are through no fault of their own and given the option most would welcome the opportunity to return to normality - certainly in terms of mental or physical limitations at least, the same cannot be said of many forms of deviance. Further, this tendency to position disability with other minority groups has allowed the several unique features of this most

fundamental - albeit unrecognised - of social phenomenon to be overlooked as hopefully this essay will demonstrate.

With reference to the opening quotation my own interest in this subject can be explained with some trepidation on my part by the fact that I was born with a hereditary eye disease which meant that I was educated at special schools for the deaf and blind until the age of eleven and had it not been for the remarkable, pardon the pun, far-sightedness of my parents would have remained there until the school leaving age - then fifteen. This would have meant that I would have ended up in a 'sheltered' workshop for the handicapped or permanently unemployed as most of my primary school peers apparently did. After a careful reading of much current sociology it became evident that very little work had been done in this area. Therefore it seemed natural that I should look to the experience of disability as a subject for analysis.

I must emphasize at this juncture that I have much sympathy with the view of Peter Townsend in 'Sociology and Social Policy 1975' who has argued that in many instances the separation of sociology from social policy is quite illegitimate - disability it would appear is just such an instance. Throughout this analysis I have tried to remain within the boundaries of sociology although I have drawn heavily upon material from other disciplines particularly social policy. Moreover I believe it is quite legitimate for the sociologist to draw upon material from other 'sciences' in order to prove his case and this is what I have tried to do.

The following dissertation then is divided into four distinct sections, plus of course a conclusion. The first attempts to cover the problem of definition. I use the word tentatively, because there are many who would argue the very idea of applying any form of classificatory label to such a large and diverse aggregate of society is almost inconceivable. And while I have much sympathy with such arguments the fact remains that for the physically and mentally less able classification is an inevitability. Indeed for most it is essential - simply because in order to ensure the welfare benefits available - often their only source of income - they are forced to accept the stigmatizing mantle of 'disabled person'. Moreover, although this chapter briefly discusses the numerous attempts at definition which have been used in the past and even adopts a broad description for the purposes of this analysis, I am not attempting to define disability. This chapter should be seen as a ground clearing exercise simply due to the fact that many concepts need to be clarified if the problems associated with society's attitude toward the handicapped are to be fully understood.

The second part of the essay is concerned with the strategies of exclusion which our society has adopted toward the physically and mentally impaired throughout history. This chapter illustrates how the open hostility and

persecution which characterized earlier less socially and technologically diverse societies slowly gave way to what can only be described as the less predictable ambivalence associated with the modern welfare state.

Chapter three concentrates upon the less violent but none the less socially and psychologically destructive manifestations of discrimination against the handicapped which pervade the modern state. In order to appreciate the full implications of the social and institutional barriers to normality which our society has erected against such people I have drawn upon material which may, because it is untheorised be seen as unsociological, however my intention here is not to attempt some form of causal explanation, but merely to describe the extent of the phenomenon in question.

The consequences of these strategies of exclusion, both for the disabled as a group and the individual disabled actor, are the topic of chapter four. This analysis of the experience of disability emphasises the unique features of this phenomenon and attempts to demonstrate that although a sociology of disability will inevitably draw upon 'conventional' conceptualization within sociology there are indeed several distinct dimensions to this subject that warrant the formulation of a new frame of reference - the disabled role.

Finally the concluding remarks draw together the salient tenets of this analysis and re-emphasize the urgent need for further investigation of this, one of the most perplexing of all social phenomenon - discrimination against disabled people.

## 2. The Complexity of Definition

Disability has many dimensions - medical, economic, legal and bureaucratic. In fact one of the most significant features of handicap, both physical and mental, and the problems it creates both for the individual and society, is its sheer diversity. Differences in causation alone are indeed many while the degree of dissimilarity between impairment, severity and prognosis are often quite extreme. It could be argued that the experience of handicap is no respecter of class, age, sex or ethnicity. Although undoubtedly different social classes are exposed to different causes of impairment. For example, the upper classes are less likely to suffer disabilities associated with heavy industrial work such as coal mining than are the working class. Equally ethnic minorities are often subject to racial discrimination and economic deprivation and may have a higher instance of diseases associated with poverty such as rickets than other social groups. But generally it would be true to suggest that disability can strike anyone, regardless of his or her social rank or status.

A disabling condition can be acquired at any age or because of deformity or congenital illness be a lifelong experience. How we respond to a disabling condition, both as individuals and as members of society can be equally diverse. Within the ranks of the disabled there are stark contrasts of success and failure, optimism and pessimism, hope and despair. At the societal level we can find instances of total acceptance or stigmatization and rejection. Some communities react with superb care and support while others care little. However, despite this diversity all those who are perceived to be disabled are disadvantaged to some degree, both by their condition and by society. But at this point we must begin to make distinctions. It could be argued that we are all prone to some measure of physical or cognitive limitation which in certain circumstances can prove totally debilitating. Obesity, agoraphobia, vertigo or stammers can all be in many ways socially disabling conditions. As individuals we are a multiplicity of strengths and weaknesses and each of us will experience limitations and frustrations in our daily lives. But the degree of social disadvantage incurred by someone completely paralysed from the waist down who has not only lost the use of their legs, but also their bowels, bladder and sexual organs, as a consequence of which are totally dependent upon others for the most basic of bodily functions, is vastly different from that of some who suffers from a speech impediment.

'Frustration, indignity, dependency and often pain and suffering. The able-bodied suffer all these at some time, but never all at once and every day without end. And what special equipment have the disabled got? None, they are the same jumble of vices and virtues, the same jumble of needs. And this is the point, isn't it? Our bodies may not look nice or function properly, but our minds hearts and emotions are the same'. (1)

The difference between the disabled and the able-bodied in terms of experience then is not one of kind but one of degree. Such a realization seriously weakens any arguments for discrimination or segregation. Nevertheless because disability is generally regarded as abnormal some form of definition is inevitable.

The problem of definition is indeed complex especially since our society seems to be constantly re-defining what is to be regarded as a disability and what is not. For example once left handedness was considered a handicap, associated with backwardness and stupidity. Thankfully today such notions are seen to be superstitious nonsense. Again homosexuality, despite the fact in some quarters it still generates a degree of antipathy and even hostility generally it is not considered a physical or cognitive handicap. And yet as one author has pointed out, not long ago homosexuality was considered a disabling condition. In 1949-50 the British medical journal 'The Lancet' ran a number of articles concerned with the realities of living with a disability. Among the topics covered was one account by a lesbian woman who discussed her life and innermost feelings (2). Conversely, epilepsy was once considered nothing more than an inexplicable rather than a major source of impairment. Indeed many cultures saw epileptic seizures as some form of metaphysical interruption which somehow endowed the sufferer with supernatural insight. And many famous leaders of the past such as Julius Caesar and Napoleon are said to have suffered from this condition. Whereas in the modern epoch it is seen as a major source of disability (3). The inability to read and write is now considered a disabling condition. There is even a medical condition - dyslexia - which attempts an explanation of the phenomenon. But not less than one hundred years ago the ability to read and write fluently would have been considered the exception rather than the rule.

While it is true to argue that our perceptions of disability are constantly changing and indeed some human traits are no longer considered barriers to normal social integration. Generally as our society becomes ever more socially and economically complex, the boundaries which encompass the physically and cognitively limited are constantly being redrawn to include more and more people.

The tendency to constantly reconceptualise our frame of reference as to who is disabled and who is not has been highlighted by M Blaxter in her 1976 analysis 'The Meaning of Disability'. She draws our attention to the expansion of society's charitable attitude toward the innocently disabled - the deaf, the blind and the cognitively sick. She shows how benefits and services had to be enlarged to include those who were crippled by war and modern industry. In Blaxter's assessment the continuous expansion of the boundaries of disability and the essential services that are deemed necessary to cope with such phenomenon has meant that the fiscal demands of such commitment have

begun to conflict radically with the humanitarian principles our society claims allegiance to.

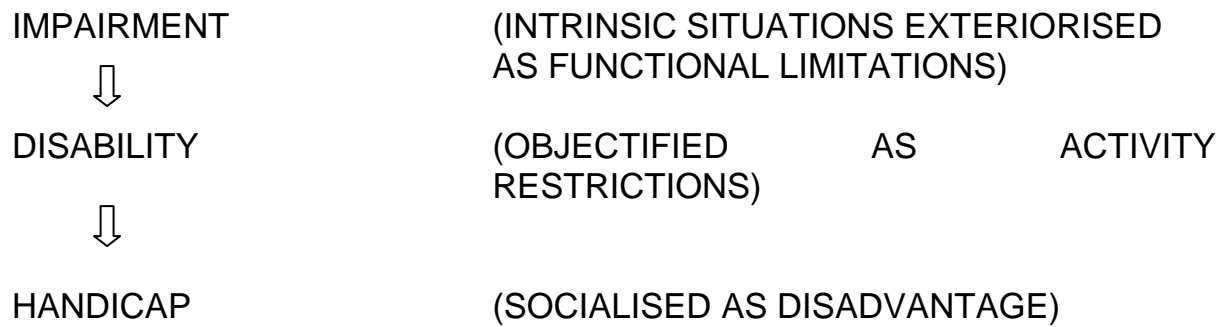
Definitions become even more difficult when we realize that disablement is not only a matter of social consciousness or official medical attitudes. Any form of classification must take account of the personal view of handicap as articulated by the disabled themselves (4). Official and other perceptions of handicap often conflict with those of the individuals themselves. The individual is often introduced the idea that a person whose normality of social identity is fragile and negotiable. He or she may occupy a position uncertain and ambiguous usually at a distance from what most people would regard as society's core institutions and values (5). To some extent society but 'occupy a marginal position uneasily situated between a rigid dichotomous social classification and undifferentiated 'normality' (6).

Although it is evident that definition is anything but simple we have to begin somewhere. Therefore it is important that such words as impairment, disability and handicap be given a specific meaning as they are often used interchangeably and their meaning may be unclear. There is some degree of consensus over the use of such terms. The Office of Population Census and Surveys conducted a massive survey of the disabled in the late 1960s and decided upon a three-fold distinction as follows.

1. **IMPAIRMENT** refers to any psychological, physiological or anatomical structure or function of the body which is defective. It may be a permanent or a temporary condition. It may be congenital or acquired. A neutral objective description of a condition.
2. **DISABILITY** concerns the impact of impairment upon the performance of activities. Commonly accepted as the basic needs for every living – walking, eating, using the toilet etc.
3. **HANDICAP**. The disadvantage or restriction caused by the disability. An evaluator concept -

'in which the interaction of impairment and disability with an individual's psychological make-up, the resources available and social attitudes effects adversely the performance of ordinary roles. (6)'

Handicap is a term usually applied by others to an impaired individual because of their failure to perform normal social roles in everyday life because of their disability. Of course some disabled people do apply the label to themselves. To move from impairment to handicap is to cover the ground between symptom and social role. Expressed in diagrammatical form it is as follows.



Source – Bury (7)

Of course the presence of impairment does not always imply disability nor disability handicap. Two people with similar functional limitations often react to the circumstances in which they find themselves completely differently. Here variations in resources both personal and communal are extremely important.

In Britain quantitative analysis of the handicapped to date has provided relatively adhoc and inconclusive. The first attempt at such an enterprise occurred in the census of 1851 which posed questions concerning the deaf and blind. However, they were dropped in 1921 on the grounds that it was considered – ‘too difficult to frame appropriate questions in such a general survey’ (8). Consequently no census has attempted such an undertaking since.

However the British people were medically examined for the first time ‘en masse’ in 1917 for military service. It was concluded that 10% of the total male population were unfit for military service, 41.5% (in London 48-49%) had marked disabilities, 22% had ‘partial’ disabilities, while only a third were considered to be in satisfactory shape. It is important to note that the author who reported these findings does not give any details of criteria used in the examinations. He does however go on to claim that

‘the working classes were stunted and debilitated by over a century of industrialization’ (9)

More recently the Disabled Persons (Employment) Act of 1944 and the National Assistance Act of 1948 required that records be kept but were only concerned with those in receipt of services (10). By the 1960s the then Ministry of Health instigated a research programme which culminated with the study conducted by the Office of Population Census and Surveys mentioned earlier. A quarter of a million households were surveyed 8,538 of which were subsequently followed up and interviewed in depth. Two books were produced from this research, J. BUCKLE's 'Work and Housing of Impaired People in



Great Britain' 1971 and A. HARRIS' 'Handicapped and Impaired in Great Britain' 1971. The measurement of the extent of handicap was based on a series of questions designed to yield functional assessments of disability. Questions were structured in such a way as to assess the disabled individual's ability to look after himself. The responses were then graded according to whether the respondent was capable of managing a given task - without difficulty, with difficulty or with help. Quantified responses were then graded into four categories. According to these functional estimates there was said to be 7-8% of the total population or 3.071000 impaired people living in the U.K. Harris estimated that each category contained the following number of people

VERY SEVERLY HANDICAPPED	157 000
SEVERLY HANDICAPPED	356 000
APPRECIABLY HANDICAPPED	616 000
IMPAIRED	<u>1 942 000</u>
	3 071 000

The Harris survey also illustrates two other important variables A/ Handicap increases with age and B/ Disabled women outnumber men in the older age group. Generally speaking there are more disabled women in the population than men. Although up to the age of 50 men are more likely to be defined as disabled than women. Possible reasons being that as a rule men tend to work in heavier, dirtier industries than women. Consequently risking injury and work oriented diseases. One writer has reported that in the first half of the 1970's there were over 12,000 major industrial accidents in the U.K. alone and there are over fifty one officially recognised industrial diseases in the same country (11). Men also tend to indulge in more dangerous sports and leisure activities than women. Whereas the high number of disabled women in the population after 50 is simply due to the fact generally women live longer than men and many crippling conditions increase with age (12).

TABLE 1

ARTHRITIS  
 (EXC. R.A.)  
 RHEUMATOID ARTHRITIS  
 STROKES AND PARKINSONISM  
 CARDIORESPIRATORY DISORDERS  
 TRAUMAS AND AMPUTATION  
 DISORDERS OF INFANCY AND YOUTH  
 MULTIPLE SCLEROSIS  
 OTHER RHEUMATIC DISORDERS  
 OTHER SYSTEMS  
 MISCELLANEOUS  
 PARAPLEGIA/HEMIPLEGIA  
 NEOPLASMS  
 SENSORY

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

% OF TOTAL HANDICAP (SEVERE AND VERY SEVERE) SOURCE;  
 WOOD, IN TAYLOR 'PHYSICAL IMPAIRMENT – SOCIAL HANDICAP' 1977

The above table shows the major causes of severe and very severe handicap in adults of working ages, between 16-65 in the British Isles.

The following table shows the estimated numbers of disabled men and women in different age groups with some impairment living in private households.

TABLE 2

AGE GROUP	MEN	WOMEN	MEN AND WOMEN
16 – 19	50 000	39 000	89 000
30 – 49	197 000	170 000	366 000
50 – 64	408 000	433 000	833 000
64 – 74	356 000	559 000	915 000
75 & OVER	243 000	625 000	867 000
ALL AGES	1 247 000	1 825 000	3 071 000

SOURCE: HARRIS 1971 Page 4

Peter Townsend in 'Poverty in the United Kingdom' 1979 argues the definition applied by the Harris study was too constricting. And further it seriously underestimates the numbers of disabled people in the British population for Townsend -

'disability itself might best be defined as inability to perform the activities, share in the relationships and play the roles which are customary for people of broadly the same age and sex in society'. (13)

TABLE 3

COMPARISON OF SURVEYS OF DISABLED IN BRITAIN

HARRIS 1971			TOWNSEND 1979		
DEGREE OF HANDICAP	OF TOTAL NUMBERS		DEGREE OF INCAPABILITY	OF TOTAL NUMBERS	
VERY SEVERE	161 000		VERY SEVERE	325 000	
SEVERE	366 000		SEVERE	780 000	
APPRECIABLE	633 000		APPRECIABLE	1 990 000	
MINOR	699 000		SOME	3 915 000	
NO HANDICAP	1 297 000		LITTLE OR NONE	2 890 000	
TOTAL	3 146 000		TOTAL	9 900 000	

SOURCE: OLIVER Page 41

There are however two points which demand clarification. First the Harris figure of 1 297 000, 'those with no handicap' refers to people with impairments but no handicap, that is according to Harris' definition. Secondly the Townsend figure of 2 890 000 'with little or no handicap' includes 180 000 children below the age of nine. The Harris study does not take account of children (14).

The figures produced by Harris have not proved reliable for estimating benefits as one author has observed (15). The main reason being that different government departments employ different definitions; moreover functional definitions are not acceptable to everyone. Victor Finkelstein has argued that they still locate the cause of disability at the level of the individual.

For Finkelstein it is society which handicaps impaired people by not providing adequate facilities for their complete integration. He goes on to suggest a reversal of the terminology used by Harris -

‘I suggest changing the definition of the words handicap and disability around. In this way a person is disabled when he is socially prevented from full participation by the way society is arranged’ (19).

Another disabled writer has proposed the definition should not be based upon incapacity but simply on the degree of stigmatization or discrimination they experience on the basis of their physical condition (17). While it is clear that such an idea would cause a great deal of controversy and debate, the fact remains that any attempt at classification must take account of the views of the disabled themselves. Indeed the inaugural meeting of the Disabled People’s International, representing more than fifty nations, recently rejected the International Classification of Impairment, Disabilities and Handicap proposed by the World Health Organisation 1980 (summarized earlier). On the grounds that it came too close to medical and individual definitions of disability (18).

While it is true to argue that handicap is socially produced and disability is the result of the individual's failure to adjust to his impairment, much of the responsibility for such a failure must lie with our society. But the fact remains that the disability which results from a broken neck is quite distinct from that incurred by say a speech impediment. While it would be quite correct to argue that the degree of handicap incurred by the latter is almost entirely attributable to society the same cannot be said of the former.

Undoubtedly much has to be done to reduce the degree of handicap experienced by the disabled. Yet the fact remains that a society which is able to accommodate equally every disabling condition is inconceivable. Therefore some form of definition is essential if the disabled are to receive the positive legislation they need. Nevertheless, the emphasis must not be placed entirely on the individual's incapacity to cope with the everyday world as exemplified by the first objective of the International Year of the Disabled 1981 (19). Nor can the responsibility rest entirely with society.

It is clear then that a satisfactory definition of disability be situated somewhere between the medical and social descriptions, and must include the single unifying factor which is associated with all disabling conditions, impairments or handicaps - disadvantage. Therefore for the purpose of this analysis I will adopt a definition which in my view incorporates these three principal elements. Thus the disabled are 'those who suffer any degree of social, economic or political disadvantage by virtue of their physiological or psychological limitations'.

However a further problem of classification particularly for the sociologies is, are the disabled a social group or social category analogous to other minority groups? Do they share the same degree of 'awareness' or 'group consciousness' as other social groups such as Blacks or Women? Undoubtedly

'there is a difference between physical disability and ethnic minority membership and an individual disabled person may not regard him or herself as a member of a group although they may evoke stereotype responses in others'.  
(20)

The picture is also clouded further by the fact that in recent years there has emerged in some, a group feeling and solidarity which have many features of a social group – special services, separate ministerial responsibilities and the emergence of various pressure groups which suggest a growth of collective awareness. As yet such groups are fragmentary and impotent but the appalling conditions in which some physically and mentally handicapped people find themselves living may prompt a change in the current situation. So far we have concentrated upon the difficulties associated with defining disability. In contrast, a definition of the discrimination they experience is relatively simple.

In the neutral sense discrimination is an indispensable element of rationality. The Oxford English Dictionary clearly states – to discriminate means to make a distinction, to perceive or note the difference (between things), to exercise discernment. Moreover to make distinctions, to enjoy the luxury of choice and preference are intrinsic to our way of life, and any individual should not expect to be exempt from such a fundamental reality. Indeed the disabled could and should not want to be excluded from such normality as the Report on the Restriction Against Disabled People 1982 makes abundantly clear from the start.

However, the most casual of observers of human affairs will be acutely aware discrimination in the modern epoch has acquired a further disparaging dimension. The dictionary explains further to discriminate against: to make an adverse distinction with regard to; to distinguish unfavourably from others'. But even here careful analysis will reveal still further ambiguity. Does our society not need to legitimize such discrimination in certain areas? Distinctions are imperative in terms of experience and qualifications when selecting individuals for jobs etc. The socially divisive sinister elements of discrimination are more obvious when applied on the basis of socially incongruous criteria such as racial characteristics, sex or in the instance of this discussion physical or psychological limitations or abnormalities. As it is the latter which concerns us here we shall adopt the definition from the

C.O.R.A.D. report which is broad enough to cover the two dimensions of discrimination experienced by the handicapped – unintentional and indirect – intentional and direct. The former refers to structural and architectural barriers such as stairs, access and fire regulations. The latter refers to the more blatant manifestations of prejudice and ignorance, where people with obvious disabilities are refused admittance to pubs or clubs on the grounds that they would ‘upset the other able-bodied customers’. For the C.O.R.A.D. committee the definition is as follows -

‘the unjustifiable withholding whether intentional or not, of some service, facility or opportunity from a disabled person because of that person’s disability (21)

In the following pages I will attempt to trace the origins of our attitudes towards the disabled, briefly outlining the complex strategies of exclusion which our society has adopted toward such people.

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18. Oliver, Michael., *Social Work With Disabled People* (1983) p 18.
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### 3. ORIGINS OF DISCRIMINATION

To pinpoint precisely the root causes of our attitudes toward the disabled would, I believe, be almost impossible. One author goes so far as to suggest that our primitive ancestors lived in such an extremely harsh hostile environment, which placed such a high emphasis upon the basic techniques of survival, that there could be no margin for the provision for those unfortunate members of society who were unable to take care of themselves, such as the weak, the sick and the disabled(1).

With the advent of basically stable communities which were able to produce a limited economic surplus, due principally to the evolution of some form of agriculture, the possibilities of survival for the physically and mentally incapacitated became more feasible although social acceptance was much more difficult.

Humanity's perceptions of disability are coloured by deep-rooted psychological suspicions of the unknown, the inexplicable, the abnormal and the ambiguous. Certainly the very concept of normality is one not merely of statistical measurement, quantitative analysis or substantiation, but is endemic to our consciousness, anchored to our perceptions of rightness and fitness. We generally cling to norms or rules of behaviour which are seen to be of moral worth. Consequently, the whole notion of abnormality can carry with it implications of disorder, badness and a threat.

Mary Douglas in her anthropological analysis of ritual and pollution 'Purity and Danger 1966' has suggested that our society has adopted several strategies for dealing with such anomalies. Negatively we can then pretend they do not exist. Or, after acknowledging their existence, we can condemn them. Positively we can accept the anomaly and endeavour to re-construct new patterns of reality in which they are accommodated. It is generally accepted that it is more or less impossible for the individual to create his or own schema of classification. No individual lives in complete isolation. Consequently his or her concepts of reality will have been partially, if not wholly received from others. Therefore culture -

'in the sense of the public, standardized values of the community, mediates the experience of individuals. It provides in advance some basic categories, a positive pattern in which ideas and values are truly ordered. And above all, it has authority, since each is induced to assent because of the assent of others'. (2)



Individual perceptions of reality may vary slightly, however at the societal level cultural concepts are invariably more rigid. Society has to provide explanations for the inexplicable. Therefore such anomalies as congenital deformity and disability it cannot be ignored.

Seemingly less complex societies have reacted to such events by erecting ideologies, moral justifications for the rejection of the abnormal. The anthropologist E.E. Evans Pritchard reported that the Nuer, a deeply religious African tribal culture, saw the birth of an unusually large child as a threat to the natural dichotomy between humanity and the animal world. For the Nuer such an event was an accident of nature which could be corrected. As a result these unfortunate infants were quietly returned to what was thought of to be their natural relatives - the hippopotamuses and their natural habitat - the river (3). Another example of a similar culture's response to such apparent anomalies is illustrated by Mary Douglas' description of a West African community which believed two humans cannot be conceived in the same womb at the same time.

Therefore twins were mercilessly murdered at birth(4). Infanticide was widespread among technologically less developed societies, especially for the physically or mentally impaired. As Michael Tooley explains -

'It was very common to destroy infants that were deformed or diseased or illegitimate or regarded as ill omens'. (5)

If abnormality and deformity were seen to be a threat to society it is relatively safe to assume that disability in many cultures was seen to be a pollutant. Unwholeness was seen to be unholy. There are many ancient prohibitions against people with deformities or abnormalities being associated with God. Some religious institutions were renowned for their overt rejection of the physically and mentally imperfect. Disease was perceived as a consequence of wrongdoing. The Hebrews associated Leprosy with sin. Indeed much of Leviticus is devoted to a reiteration of the physical perfections necessary for all aspects of religious ritual. As God said to Moses -

'none of your descendants, throughout their generations who has a blemish shall draw near,

A man blind or lame, or one who has a mutilated face, or a limb too long, or a man who has an injured foot or an injured hand, or a hunchback, or a dwarf, or a man with a defect in his sight, or an itching disease, or scabs, or crushed testicles ..... He may cast the bread of his God, both of the most holy and of the holy things. But he shall not come near the veil or approach the altar, because he has a blemish, that he may not profane my sanctuaries'. (6)

In many instances present practices echo ancient prejudices. Emile Durkheim has drawn our attention to the fundamental impact religion has played in the

formation of different societies and their institutions. He acknowledged it to be one of the, if not the principal source of all subsequently evolved moral, philosophical, scientific and juridical ideas (7).

However, it would be erroneous to make the unprecedented assumption that all religions have reacted negatively to the all unequivocally rejected the practice of infanticide. Indeed some cultures believed that those seemingly less fortunate than the majority were in possession of some intangible metaphysical gift. Ritual has always recognised the potency of disorder. Especially disorders of the mind, fits, faints and frenzies were often interpreted as some form of transition to a higher consciousness, a passage to a higher plane where power and truths were sometimes revealed, not normally accessible to the conscious mind. Certainly the mentally ill were seen to have use value. The Ehanzu, a tribe in Tanzania, believed that in order to guard against sorcery and ensure the return of the annual rainfall a 'simpleton' had to be sent into the bush to wander alone until the rains came(8).

It was not until the time of the Ancient Greeks that any form of 'scientific' inquiry into the problems of disability was undertaken, which did not turn to the supernatural for explanation. And it is also generally accepted that the Ancient Greeks made ample provision for those who were disabled in battle. Although it is quite clear that like the other most advanced culture of Ancient Europe Rome, the Greeks were advocates of infanticide for the weak and deformed. In Sparta it would seem such practices were demanded by law(9). However Aristotle had attempted to study deafness. For him it was a direct barrier to the central processes of learning, language. Galen and Hippocrates perceived epilepsy as a physiological interruption to the normal mechanisms of cognition (10)

Certainly the inception of Christianity with its magnanimous attitudes towards the inflicted appears to have done much to improve the material conditions under which they lived. But it did relatively little for their status in the community. As one writer has pointed out the spirit of naturalistic enquiry begun in Ancient Greece was subsequently abandoned for a thousand years. Generally in the Europe of the medieval period the physically and mentally incapacitated were the recipients of superstition, persecution and ridicule.

Since disability and abnormality were seen to be unclean or impure, they were also associated with evil and witchcraft. C. Haffter has pointed to the fact that in the European Societies of the middle ages deformed or disabled children were seen as 'changelings' – substitutes for human children, the outcome of the parents' involvement with black magic or sorcery. The Malleus Maleficarum of 1387 declared that deformed infants were the outcome of the mother's intercourse with the Devil (11). The notion that any form of physical or mental disability was a judgment for wrongdoing was, and to some degree

remains so today, pervasive throughout Europe during this period. Epilepsy was particularly prone to such superstitions at this time. William Shakespeare's Richard the Third illustrates the discrimination experienced by someone born into a world which places such a high emphasis upon physical normality.

'Cheated of feature by dissembling nature/  
deformed, unfinished sent before my time/  
into this breathing world scarce half made up/  
and that so lamely and unfashionable/ the  
dogs bark at me as I halt by them'.

Shakespeare portrays Richard as twisted in both body and mind. Since he cannot prove a successful lover because of his affliction he is determined to become a successful villain. Such associations were not only limited to the layman.

The German religious leader and scholar, accredited with the inspiration for the foundation of the Protestant reformation, Martin Luther (1483-1546) believed he saw the Devil in a profoundly handicapped child(12). As a result of such ideas disabled or deformed infants were the focus of a mixture of emotions which embodied guilt, fear and contempt. Such children became a 'shameful stigma' in the eyes of the rest of society and a major reason for ostracism, persecution and rejections.

The afflicted were also an object of ridicule during this period. Keith Thomas' analysis of the joke books of the England of the Tudor and Stuart period illustrates beautifully this further dimension to the discrimination experienced by the handicapped at this time. Besides references to the seemingly timeless universals of popular humour – foreigners, the wife, the church and so on there are many jokes devoted to the mentally and physically disabled.

'Every disability, from idiocy to insanity to diabetes and bad breath was a welcome source of amusement 'we jest at a man's body that is not well proportioned' said Thomas Wilson ..... 'and laugh at his countenance if ... it be not comely by nature'. A typical Elizabethan joke book contains 'merry jests of fools' and merry jests at blind folk. While some of the tricksters pranks are brutal in the extreme'. (13)

Thomas concludes with the statement that most professions were closed to the disabled, visits to bedlam were a common form of entertainment for the socially well placed and the practice of keeping 'idiots' as objects of amusement was common among the aristocracy. At the lower level Thomas recalls John Bunyan's account of the ale house-keeper who kept his poor idiot son Edward to entertain his guests (14).

However, it is also evident that the Tudor and Stuart periods were significant for society's recognition of the hardship experienced by those at the bottom of the social hierarchy - the poor and the sick. Certainly up until this time such people had to rely upon the benevolence of monasteries and the charitable. But during the reign of Henry VIII some English towns such as London and Ipswich organised some form of administrative relief for the less fortunate. By the end of the Elizabethan period such 'social services' had become a duty prescribed by national legislation. Such action was forced upon local magistrates by the Privy Council and paid for by compulsory Poor Rates(15). The Poor Law of 1601, Section 1, makes explicit reference to providing special facilities for the lame, the infirm and the blind(16). By the end of the seventeenth century this new sensitivity had taken hold certainly among the upper echelons of society.

William Hay born in 1695 – a typical gentleman of the period, a country squire, a Justice of the Peace and a Member of Parliament wrote an essay one year before his death titled 'Deformity' 1754. It is in essence a philosophical approach to the subject of disability. A subject in which he was well equipped to articulate. He describes himself as scarcely five feet tall with a back 'bent in my mother's womb'. (17) His purpose in writing the essay was to outline the problems he had encountered throughout his life. He believed his condition had caused him to be bashful, uneasy and unsure of himself. He was also extremely self conscious of his personal appearance and considered himself to have been extremely fortunate to have been born into a social strata where such a high emphasis was placed upon good manners and politeness. Thus preventing any 'gentlemen' making any derogatory remarks concerning his appearance. He notes however how the gentle friendly teasing of his close friends and their high standards of social etiquette they observed were in marked contrast to the less sympathetic behavior of the lower classes –

'where insolence grows in proportion as the man sinks in condition'. (18)

The apparent dichotomy between the behavior directed toward the afflicted by the two social groups he attributed to breeding and education.

The advance of capitalism and its subsequent outcome – the Industrial Revolution, the origins of which, particularly for England, were firmly established before the thirteenth century according to one historian(19), was to further reduce the life chances of the less able members of society.

Because the capitalist mode of production and all that it entailed – mechanization, mass production, the disciplinary power exercised in the newly developed factories and the social hierarchy were all geared toward the mentally and physically agile, the disabled were further excluded from the

world of work. It is crucial to the capitalist ethos that individuals are judged by what they achieve. And theoretically at least the economic rewards and status are structured accordingly - what Claus Offe refers to as the 'achievement principle' (20). Consequently the disabled were separated from the mode of production, not merely because of their inability or unwillingness to work but simply because of the way the new industrial processes were structured under capita.

The disabled, along with the other disaffected groups in the society of the eighteenth and nineteenth centuries, had become dependent upon the rest of society, or as one writer has claimed part of what Marx referred to as the 'reserve army' of workers.

'The industrial reserve army consists of not only the unemployed, but also marginal groups like the disabled, the seasonally employed, those displaced from previous modes of production (like peasants), immigrants from other countries and especially important today housewives'. (21)

In a sense their function is to reduce the potentiality for revolution by exerting downward pressure upon wages. Thus maintaining high profit margins and of course filling gaps in the labour market when the necessity arises.

The problem of course for capital is the maintenance of the reserve army, without it acquiring the potential for revolution – a class consciousness arising from dissatisfaction. Which large groups of disaffected minorities may provoke. Michel Foucault points to the fact that –

'sickness is only one among a range of factors including infirmity, old age, inability to find work and 'necessitous pauper' who deserves hospitalization' . (22)

Such an essentially class based analysis suggested by Foucault and explicitly Zola (23) argues convincingly that the medical profession and other associate professions are by implication little more than agents of social control – in the service of the capitalist ruling classes. They cannot be members of that class as they do not own the mode of production. Yet it is argued they are acting for those that do by effectively maintaining the capitalist system as it stands.

The growth of these large institutions which spread so rapidly throughout Western Europe during the late eighteenth and nineteenth centuries adds further weight to the argument that in fact they were covert mechanisms for regulating the size of the industrial reserve army. While such arguments may have some degree of credence especially in the case of many psychological disorders where patients were institutionalized unnecessarily and certainly there is a grey area between a number of psychological and physical conditions in which the two are not easily separated. To suggest that the

medical profession and nurses in particular are nothing more than disguised jailers is largely unfounded in my opinion.

Nevertheless as such establishments proliferated their very existence merely served to reinforce society's perceptions of disability and handicap. The disabled were sick, less than human, helpless and incapable to living in the community. Their very presence was seen to be a threat to the very health of society itself. As a consequence discrimination, rejection and segregation proliferated also.

As the nineteenth century progressed the transition from relatively light industries such as textiles to the much heavier capital goods industries like iron, steel and the railways, what E.J. Hobsbawm referred to as the 'second phase of industrialization' (24) further exacerbated the subordinate position of the physically and mentally weak. Simply because such work demanded such high degrees of strength and fitness.

Emphasis on physical and cognitive abilities was further endorsed with the publication in 1857 of Charles Darwin's 'The Origin of Species'. It was the culmination of Darwin's (1807-1882) observations and explorations on the voyages of the Beagle. His work besides developing his monumental theory of evolution placed great emphasis upon the process of natural selection and the survival of the fittest. Darwin's ideas were to provide the foundation upon which an ideology was constructed which remained popular as long as the class of competitive free enterprise retained its ascendancy. Social Darwinism dispelled and allayed the qualms of the rich not helping the poor and weak by telling them that the latter's sufferings were the inevitable price of progress which could only occur through the struggle for existence. The inevitable outcome would be the survival of the fittest at the expense of the unfit who would be eliminated. Endorsed by nineteenth century luminaries like Herbert Spencer (1820-1903) such ideas were to have significant repercussions throughout Victorian Europe. The fallacies inherent in social Darwinism were exposed by many as soon as it was formulated. Probably the most well known being the Russian Anarchist Prince Kropotkin whose book 'Mutual Aid' showed how even among sociable animals individual survival depends upon group solidarity within the group. While others pointed to the fact that victory in the race for wealth cannot be associated with natural selection as the poor procreate faster than the rich. (25)

However, besides the horrors of institutionalization described so eloquently in the novels of Charles Dickens, the nineteenth century was also significant for the upsurge of Christian morality which was to have such profound effects upon the lives of the poor and the disabled.

The extreme hardship experienced by those unable to sustain a reasonable standard of living was to stimulate in many Victorians, fired by the new found

Christian morality, a desire to help those less fortunate than themselves. A mixture of bourgeois altruism and conscience, this spirit of Victorian patronage is epitomised by the character Scrooge in the same author's famous novel 'Christmas Carol'. A more tangible example of nineteenth century benevolence would be Sir Frederick Treves (1853-1923) who successfully raised money for the rescue and care of John Merrick - the so-called elephant man.

The story of how Treves befriended and rescued John Merrick is now extremely well known. Due principally to the enormous success of the recent stage play starring David Bowie and the motion picture which had John Hurt in the title role. The story of John Merrick's life is important simply because it illustrates beautifully the startling ambivalence Victorian society displayed toward the disabled. Before his rescue John Merrick had been subjected to untold cruelty and humiliation. He was an object of ridicule - a pathetic curio in a fairground freak show. After Sir Frederick Treves' intervention Merrick became the focus of attention for a large number of upper class society, who were not only generous but apparently kind and considerate. In a sense Merrick had become a symbol of Victorian virtue and altruism.

The unprecedented upsurge of religious ethics which characterized the Victorian epoch also put an end to the widespread practice of infanticide for the physically and mentally impaired, which despite the dominance of the Christian Church throughout Europe, had been the rule rather than the exception until the nineteenth century according to Michael Tooley's analysis. (26)

Without question the positive changes which took place during the nineteenth century were to have profound effects upon the lives of the disabled. The overt hostility and rejection which had characterized earlier epochs had begun to disappear. Society began to display a degree of tolerance and acceptance which had not existed in earlier times. However, the ambiguity which epitomized Victorian attitudes toward the handicapped remains. The humanitarian morality which flowered during the last century has not put paid to ignorance and misunderstanding. While blatant segregation and hostility have disappeared generally. Contemporary society has created new strategies of exclusion which *are* equally debilitating. The following pages are concerned with how these phenomena manifest themselves in the modern epoch.

1. Thomas, David., *The Experience of Handicapped* (1982) p 21.
2. Douglas, Mary., *Purity and Danger* (1966) pp 38-39.
3. Evans Pritchard, E.E., *The Nuer Religion* (1956) p 64.
4. Douglas, Mary., *Purity and Danger* (1966) p 39.
5. Tooley, Michael., *Abortion and Infanticide* (1983) p 315.
6. Shearer, Anne., *Disability Whose Handicap?* (1981) p 75.
7. Giddens, Anthony., *Capitalism and Modern Social Theory* (1971) p. 105.
8. Douglas, Mary., *Purity and Danger* (1966) p 94.
9. Tooley, Michael., *Abortion and Infanticide* (1983) p 316.
10. Thomas, David., *The Experience of Handicap* (1982) p 22.
11. Haffler, C., 'The Changeling: History and Psychodynamics Attitudes to Handicapped Children!' *Journal of the History of the Behavioural Sciences*, No.4, (1968) pp 60-61.
12. Shearer, Anne., *Disability Whose Handicap?* (1981) p 77.
13. Thomas, Keith., 'The Place of Laughter in Tudor and Stuart England', *The Times Literary Supplement*, 21 January 1977.81 pp 80-1 in Thomas, David., *The Experience of Handicap* (1982) p 23.
14. Ibid., P 23.
15. Trevelyan, G.M., *English Social History* (1964) p 112.
16. Oliver, Michael., *Disability into the Eighties - A Review Article* (1983) p112
17. Thomas, David., *The Experience of Handicap* (1982) p 25.
18. Ibid., P 26.
19. MacFarlane, Alan., *The Origins of English Individualism* (1978).
20. Offe, Claus., *Industry and Inequality* (1976).
21. Gough, Ian., *The Political Economy of the Welfare State* (1979) p 25.
22. Foucault, Michel., *Power and Knowledge* (1980) pp 168-169.
23. Zola, 'Medicine as an Institution of Social Control', *Sociological Review* (1972) Vol. 20, pp 487-504.
24. Hobsbawn, Eric, J., *Industry and Empire* (1968) p 88.
25. Andreski, Stanislav., *Herbert Spencer* (1977) p 26.
26. Tooley, Michael., *Abortion and Infanticide* (1983) p 317.



#### 4. DISCRIMINATION IN MODERN SOCIETY

The rise of Capital in Western society has done little to change our attitudes toward the disabled. Indeed because of capitalism's commitment to sustained economic growth it has served to exacerbate discrimination rather than alleviate it.

By definition, Capitalism is a system of commodity production which is principally organized for the creation of profit. Profit is necessary for several reasons. Firstly to satisfy the insatiable demands of the Capitalist class – the bourgeoisie. Marx described the capitalist as a 'rational miser' (1). Secondly, to ensure the reinvestment necessary to maintain the technological innovations essential to increase production methods and stave off competition, competition being endemic to capitalist society. And thirdly to placate a potentially revolutionary workforce – the proletariat, who according to Marx's analysis, remain dangerous because of the extreme inequalities which pre-dominate in such societies.

Therefore in order to satisfy the economic demands of the proletariat the capitalist state had to assume responsibility for reproduction. The capitalists themselves could or would not afford the fiscal cost of the needs of the workers in a technologically progressive society – schools, hospitals etc. As a result the state began to take a sizeable chunk of the fiscal product in order to finance these forms of collective consumption. Certainly at the end of the nineteenth century most scholars believed that the economic possibilities for the foreseeable future were almost limitless. The majority shared in the

'mood of the time, anticipating a perfect society just around the corner; or not much further behind – a society whose healthy roots were already well established'. (2)

The stark reality of the twentieth century has thus far proved otherwise. The belief that the 'hidden hand of the market' alone would effect some form of miraculous social and political equilibrium has proved fallacious. And what now seem the obvious limitations to the possibility of infinite economic growth have become all too apparent. The consequences for those who are perceived to be 'dependent' upon the rest of society (those who to some degree are actively engaged in the creation of surplus) the weak, the sick and the disabled are indeed a major cause for concern. In order to understand why the historical legacy of prejudice and discrimination remains, in a so-called enlightened age, it is necessary to have some insight at least into the mechanics of such societies. What form they have taken and what form they are likely to take in the foreseeable future.

The tendency for the modern capitalist state to adopt what Keith Middlemas in 'Industry Unions and Gov't' 1983 has referred to as the 'corporate bias' Otto

Newman has shown were present in the Germany of the Bismarckian decades of the mid-nineteenth century (3). Although in Britain the spectre of corporatism did not appear until the first world war. However the most continuous economic crises which have confronted Europe since 1900 such as increased foreign competition, especially since the decline of colonialism, or the emergence of trans-national corporations, have along with the demands of an increasingly politicized working class served to seriously undermine and de-stabilise capitalist hegemony. Lack of co-operation between gov'ts, industry and organised labour over crucial issues like wages policy necessitated moves towards some form of continuous economic and social management by the state – corporatism – or what Newman has referred to as the 'optimum face of capitalism'. Consequently the capitalist polity assumes control directing chunks of the fiscal product to develop new markets. In effect underwriting the needs of capital and placating a potentially revolutionary workforce with larger shares of the surplus. The state has assumed responsibility for pattern maintenance - welfare and cultural systems. In this sense the welfare structure concerns every element of society not directly attributable to capital - hospitals and schools etc. In essence corporatism provides a physical and social infra-structure which through mutual consensus between the three most powerful elements of society - the polity, capital and organized workforce underpins capitalist continuity.

In Britain the state formally assumed the responsibility for social welfare immediately after the 1939-45 war. But the policy of universalism which it adopted was never intended to disrupt the social hierarchy. Although the sick and disabled are now entitled to some measure of social welfare as a right. Their position in the social pecking order generally has remained as it was, before the welfare states inception - subordinate - both economically and socially to the rest of society. Furthermore, rather than redress the vast economic imbalance, even marginally that exists in British society, the welfare state as Peter Townsend has shown has merely served to benefit the 'well heeled' rather than those sections of society who need help the most, if we take into account free state education, health services and so on. (4)

A further dimension of the shift toward corporatism, which despite recent setbacks due to the upsurge of reactionary Gov'ts in many western societies is likely to be the form advanced capitalist states are likely to take, is that because the lion's share of the fiscal product is shared principally between those sections of the community engaged in the creation of profit. The consequences for those who are not are obvious. The amount of surplus allocated to each sector such as organized labour depends upon the amount of pressure they are able to exert upon the rest of society. As one author has pointed out corporatism has become simulated politics. The conflict over distribution of resources becomes institutionalized.

'The modern state is best understood not in terms of

representation of diffusely articulated interests (as the traditional liberal theory of the state would wish) but as a network of consultation, bargaining and compromise between functional simulators'. (5)

Former interest groups and representative bodies have become nothing more than appendages of the mechanisms of the state. Traditional platforms for political articulation have become cosmetic. The corporate tendency is the outcome of a polity organized for the authoritative distribution of seemingly ever decreasing resources. The result being that the weaker sections of society are afforded a smaller share of the fiscal product simply due to their lack of political clout.

Claus Offe as early as 1968 defined the role of the polity in the late capitalist state as 'cautious crisis management and long term avoidance strategies'. (6) His argument revolves principally around the premise that the modern capitalist state responds only to the needs of those groups who are in a position to seriously threaten the systems continuity. As a result those who are atomized and dispersed in the populace and not easily organizable, groups like the disabled become neglected. His analysis demonstrates how modern society neglects functional areas which are not directly linked to those who are engaged in the mode of production. These 'depressed areas' – state housing, education, health care etc, although in theory effect the entire population in reality effect only those who are perceived to be dependent upon the state - ethnic minorities, women, the old and the disabled.

Because of the depressed condition of these functional areas those actually engaged in the production process are encouraged to look to the private sector for such services. In this sense it is clear that the modern capitalist state exacerbates discriminatory action against the physically and mentally weak. But as the 'Action Group to Defend the Rights of the Disabled', (a Russian organization which over the past three years have regularly issued bulletins highlighting the deprivation experienced by its constituents in Soviet Russia) have demonstrated prejudice and discrimination are allowed to persist in other societies which claim allegiance to a different ideology. (7) Whether or not Russia constitutes a truly egalitarian society is open to conjecture. Certainly the evidence suggest otherwise. Technological and military competition with western capitalism has meant the inevitable spread of consumerism, inequality and hierarchy throughout the communist world. The result being that the experience of handicap is remarkably similar regardless of which side of the iron curtain you are from.

It would seem discrimination against the physically and mentally limited is intrinsic to most contemporary societies. Frank Rowe in 'Handicapping America' 1978 has highlighted six major dimensions to the problems of integration for the disabled - architectural, attitudinal, educational,

occupational, legal and personal. (8)

He illustrates the first element of his typology by discussing the problems associated with access to gov't buildings etc. in America. He records the number of schools not adapted for pupils in wheelchairs, and how Washington DC – the U.S. Capital's 'new' transport system 'metro' supposedly designed for the handicapped, the elderly and the able-bodied is still inaccessible for those in wheelchairs 12 years after its initial construction. He points to the fact that getting legislation for an architecturally barrier free environment through congress is easier than enforcing it.

While Britain the C.O.R.A.D. committee who based their report upon over 700 responses to questionnaires claim -

'the letters we received showed clearly that disabled people perceive access difficulties as the most fundamental cause and manifestation of discrimination and as we reflected on these letters we came to the conclusion that this perception was justifiable'. (9)

It is evident from the number of guides put out by pressure groups representing the disabled in Britain that access to public buildings and amenities which the able-bodied take for granted is almost impossible without prior notification to the parties concerned such as restaurant or cinema managers, for anyone with mobility difficulties. It is clear architectural barriers to integration for the less fortunate know no international boundaries. And yet with a little forethought and of course the fiscal resources the physical environment could be accessible to almost everyone.

The basis for Rowe's second element – attitudinal barriers – have been discussed in the previous section. He comments upon the awkwardness and falseness of encounters between the handicapped and the disabled. The prejudices and ignorance which determine such attitudes he concludes are enmeshed in the national policies which govern our lives. Society is quick to acknowledge the achievements of 'super cripples' but we are reluctant to include the majority of disabled and deformed people into the mainstream of our everyday lives. Many are segregated into institutions or hospitals. The consequences of which are boredom, apathy, loss of initiative, institutional neurosis or downright despair.

Erving Goffman in 'Asylum' 1961 discussed in lurid details the effects of such establishments on both the patients and the staff. 'Total Institutions' as he described them are characterized by a loss of privacy and a lack of freedom of choice while the individuals within them miss opportunities to make meaningful relationships. A further indictment of this system of hospitalization can be found in Paul Hunt's 'Stigma The Experience of Disability' 1966. Hunt

suffered muscular dystrophy and spent much of his short life in such places and his book can be seen as a deeply moving account of the soul destroying effects of long term institutionalization.

According to one estimate there are 76,000 people under the age of 65 in 'residential care' in the British Isles. (10) And despite the fact that it is generally accepted – at last – that the most appropriate place to live with a disability is in the community, there are many who still argue for the need for additional residential facilities such as Topliss and Gould in 'A Charter for the Disabled' 1981. Indeed according to one author

'some countries such as Italy are trying to adopt an approach that is literally radical - they have closed their institutions and special schools by act of Parliament and simply uprooted their inhabitants into the community. (11)

Probably the most fundamental illustration of the attitudes which still pervade our society, is that for the majority of disabled people there is little if any choice of opting for one type of care rather than another, many have no choice at all and end up in residential care simply because according to one source –

'it is not the degree of impairment or the progressive nature of the disease suffered by the individual, but the breakup of the family or the refusal of the carer to continue with the tasks upon which the impaired person is dependent'. (12)

Our general attitudes toward the disabled have a profound effect upon the family. The impact of disablement of course generally depends upon who is affected within the family group. Although it can be argued that regardless of who is affected the impact of disability will have significant repercussions upon the expectations and relationships of the entire family unit. It goes without saying that in almost every case the difficulties will be further compounded if the family in question is of a racial minority, a one parent family or the breadwinner is a woman. Undoubtedly the ability to cope emotionally and physically as well as financially will vary from family to family, and the burden of disability will fall unevenly across its members but its effects are never negligible.

Peter Townsend's comprehensive analysis of poverty in Britain during the 1970's concluded that over half the people with appreciable or severe incapacities were, a decade ago in households which were poor or in the margins of poverty by the state's own subsistence standard and that was compared with one fifth of the able-bodied population. In almost every age group people with disabilities are economically worse off than their able-bodied peers. As disability increases with age, so the disabled and their families can expect to be poorer. Such families can expect disproportionately

low incomes while incurring disproportionately high expenses. Children with disabilities need special toys and equipment, they wear clothes out faster, while the aged need extra warmth, incontinence pads and so on. Daphne Sanders, a disabled parent, sums up the experience of someone living under such conditions.

'My main feelings about these experiences are anger and frustration. Anger because not only do I have to cope with the physical and mental difficulties of being a person with a disability, but I have to use precious energy struggling to make ends meet. Frustration because there seems very little prospect of improvement in the situation'. (13)

Educational barriers are those which segregate children by virtue of their disability. These barriers operate not just at the level of basic schooling but in further and higher education. Despite much recent criticism of segregated education for the physically and mentally limited, both on the grounds that special schools fail to provide an adequate education when compared with ordinary schools and because of the social implication of segregating large groups of children from their peers, both the number and percentage of children in special schools in the British Isles has continued to rise steadily as the following table shows.

Table 4

YEAR	NUMBERS		PERCENTAGE
1950	47	000	0.75
1955	58	000	0.81
1960	66	000	0.86
1965	74	000	0.96
1970	87	000	1.01
1975	132	000	1.37
1977	135	000	1.39

**NUMBERS AND PERCENTAGES OF SCHOOL POPULATION IN SPECIAL SCHOOLS**

SOURCE – Page 293, Booth 1981

In response to such criticism the British gov't set up a committee of enquiry which produced the Warnock Report in 1978. The report made several

recommendations which included replacing the original categories of handicapped children with a much broader concept of 'special educational needs'. (14) The report also favoured integration into ordinary schools for most children. The subsequent gov't White Paper entitled 'Special Needs in Educational' 1980 and the Education Act of 1981 broadly endorsed such ideas. Yet central gov't made no resources available to facilitate such a transition. The Act also leaves the legal rights of the handicapped child and his or her parents unchanged. Consequently it is still the local authority or what Peter Mittler refers to as the 'Lay decision makers' (15) who decides what provision is appropriate.

In view of the fiscal constraints placed upon these elected bodies in the present economic climate by central government is it any wonder that any significant changes have not been forthcoming?

While at the level of Higher and Further education David Thomas reports that a survey of the National Union of Students in 1976 found that although more disabled students were attending higher education only 34% of those from special schools capable of entering such establishments actually made it. They recommended the adaptation of buildings to conform with the requirements of the Chronically Sick and Disabled Persons Act 1970. Applicants should be assessed on academic qualifications only and such establishments should provide information for disabled students and the setting up of committees to oversee the needs of these students. (16) In short, while some progress has been made in this area, much needs to be done in view of the ever increasing demand for qualifications for jobs. An area in which the disabled are already seriously disadvantaged.

Rowe's fifth barrier to integration, that is occupational, has obvious connotations for the impaired person. In any society one's occupational role is of paramount importance, it can provide economic security, social status and self esteem. The Disabled Person's (employment) Act 1944 laid the framework for the provision of a number of employment and rehabilitation services whilst also providing disabled people with legal rights to employment. It placed an obligation upon all employers who had over twenty employees to employ no less than 3% of the workers from those registered as disabled. It was hoped that the Act would alleviate the high unemployment levels among the disabled. However, it is undeniable that disabled workers are more likely to be unemployed than their able bodied counterparts. Employers have also been reluctant to comply with the regulations. In 1980 only 35% of firms complied with their quota and there has only been ten prosecutions for non-compliance since the act went onto the statute books in 1944. Further, it is not an offence for firms to be below their quota and an exemption certificate can be acquired if vacancies are to be filled by nondisabled workers. One writer has suggested that permits are issued every six months 'en masse' and there are only ten inspectors for the entire country. (17) Besides which the register

of disabled people in all probability underestimate the size of the problem for many people will be loathe to register for fear of jeopardising their future employment prospects.

Certainly the type of employment usually found by the disabled is essentially low paid and un-skilled. Often in sheltered workshops among other workers suffering from a wide variety of physically and mentally limiting conditions. One observer argues despite this reality

‘many people whatever their cause of unemployment will settle for a job that under uses their skills rather than continue in it’. (18)

To illustrate the point she cites the case of a civil engineer who was forced to give up his highly paid job due to incapacity through chronic bronchitis and ended up mopping floors. (19) As a general rule it would seem once disabled people with disabilities get the chance to work they tend to be more reliable and meticulous than others – primarily because they have to be in order to hold down a job.

However, by 1978 when the general unemployment rate in Britain was six percent the rate among the registered disabled was fourteen. By the end of the 1970’s nearly sixty percent of the registered disabled had been unemployed for over a year compared with about one quarter of able-bodied workers in a similar position in the country as a whole. (20) And of course as noted earlier, the whole story.

The effects of long term unemployment can be seen as a major cause of handicap for not only the disabled but also the able-bodied. The cycle of euphoria, the eventual loss of self-confidence and finally the ‘survival routine’ have all been well documented elsewhere. Dr. Harvey Brenner of John Hopkins University USA argues the effects of long term unemployment can be much worse. He has calculated a one percent rise in unemployment in the US sustained over six years would yield 37,000 deaths. Including 20,000 from Cardio Vascular disease, 1,000 suicides, 600 murders and 4,000 admissions to mental institutions. (21) Whose job according to their inhabitants is to cater principally for those who have no social status in society. In other words tantamount to social death. (22) It would appear that the lack of work not only disables but destroys.

In a society dominated by the fluctuations of the market the handicapped are unquestionably the most vulnerable section of the community. A further illustration of this reality is evident from a brief examination of the fifth barriers to integration in Rowe’s typology – the legal barriers. The most extreme examples of which can be found in the USA.



Many writers have drawn attention to the fact that in over twenty American states there are laws which permit the involuntary sterilization of disabled people. Others have pointed to the so-called 'ugly' laws which still remain on the statute books in many American states. Legislation which prohibits persons considered to be -

'diseased, maimed, mutilated or in any way deformed so as to be an unsightly or disgusting object or improper person from walking the streets on pain of arrest and subsequent fine'. (23)

Further, to ram home the point that such laws are not merely left overs from a bygone age, one author has pointed to the fact that in the state of Omaha only recently someone was arrested for just such an offence. (24)

Here in the British Isles others have asked why it took so long for the Chronically Sick and Disabled Persons Act of 1970 to become Law? Or why we in Britain had to wait until the same year for mentally handicapped children to be considered eligible for education rather than training? And why a major report such as 'Integrating the Disabled' had to wait until 1974 to be published? These are just some of the examples of the legalized discrimination which have existed, there are others. Probably the worst dimension of the obstacles facing the disabled today is the bureaucratic jungle

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'the tangled web of legislation, rights allowances and claiming procedures. Indeed so complex has the matter become that a new professional has emerged - the Welfare Rights Officer. (25)

Simpkins and Tickner have described his function as an intermediary between the layman and the law. They focus upon the disparity between legislative intent and reality. (26)

The Chronically Sick and Disabled Persons Act 1976 prescribes specific duties for local authorities to uncover the numbers of disabled people and provide a wide range of services – assistance in the home when necessary, recreation, transport and housing etc. The Act can be seen as a splendid Charter for the Disabled. At the outset it was seen as the dawn of a new epoch for the handicapped, however Simpkins and Tickner argue that in reality the Act has created bitter disappointment.

The implementation of this new legislation has been hampered by the economic climate which has inhibited the expansion of services – the reorganization of National Health structures, covert discouragement from central gov't and various regional interpretations which all give rise to a high

degree of variance in the services provided from area to area. Such differences have been compounded further by the expansion of means tests, payment scales, different criteria for services and benefits as being equivalent to 7,000 means test. They also point to the fact that so much publicity was attached to the launching of the Act that the able-bodied genuinely believe that all the needs of disabled people are now met. It is difficult for the ordinary man in the street to understand that the disabled have little or no control over their own incomes. Or that the vast number of benefits available means that all claimants receive them all. Indeed every new benefit may not be to add to the income of those already in receipt of benefit.

‘but often merely to change the label on the part of the little they already get, while at the same time adding to the complexity of choices they must make as to how to obtain the best total deal within their entitlements’. (27)

They found that there are no less than fifty five separate benefits available to disabled people, and yet despite this fact to be disabled in the British Isles still means to be one of the poorest.

1. Rowe referred to his final barrier to integration as the ‘personal’ barrier and arguably it is the most socially damaging. Physical and cognitive limitations present difficulties for the normal daily living – reduced social status, poverty and so on, but the disabled often acquire as a result of the discrimination outlined above lowered perceptions of their own worth as human beings. The consequences of which will be the subject under discussion in the following pages.

1. Marx, Karl., *Capital Vol. 1*, (first published 1861) p 590.
2. Bauman, Zygmunt., *Memories of Class* (1982) p 125.
3. Newman, Otto., *The Challenge of Corporatism* (1981) p 19.
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7. Shearer, Anne., *Disability Whose Handicap?* (1981) p 180.
8. Rowe, Frank., *Handicapping America* (1978).
9. Large, Peter., Chairman – *Report by the Committee on Restrictions Against Disabled People* (1982) p 9.
10. Oliver, Michael., *Social Work With Disabled People* (1983) p 85.
11. Mittler, Peter., *Quality of Life and Services for Disabled People* (1983) pp, 83-84
12. Oliver, Michael., *Social Work With Disabled People* (1983) pp 84-8
13. Sanders, Daphne., 'Living in Benefit' in Walker, A., and Townsend, P., *Disability in Britain* (1981) p 23
14. Warnock, Mary., Chairwoman – 'Meeting Special Educational Needs' *Third Impression* (1979) p 3
15. Mittler, Peter., *Quality of Life and Services for Disabled People* (1983) p. 20
16. Thomas, David., *The Experience of Handicap* (1982) p. 179
17. Ibid., p. 176
18. Shearer, Anne., *Disability Whose Handicap?* (1981) p 154.
19. Ibid., p.154.
20. Ibid., p.155.
21. Ibid, p.153
22. Ibid, p.153
23. Ibid, p.100
24. Low, Colin., *Some Heracles About Handicap* (1984) p 2.
25. Ibid., p. 3.
26. Thomas, David., *The Experience of Handicap* (1982) p 180.
27. Simpkins, J., and Tickner, V., *Whose Benefit?* (1978) p 36.
28. Ibid., p. 32.

## 5. The Experience Of Disability

As the previous discussion has clearly shown, to be disabled is to be discriminated against. As a result to become disabled is to acquire a new identity. To be born with a handicapping condition is to have this new identity assigned the instant the condition is detected and diagnosed. Handicapped people have to pass through a process of socialization which not only enabled them to deal with the limitations and practicalities of their condition, such as maturing Braille in the case of the blind, but also with several behavioural-attitudinal adjustments. These must involve a heightened perception of the attitudes of others as well as a systematic re-appraisal of themselves. As a rule the disabled are stereotyped by the rest of society. They often suffer the ambiguity of being socially ostracized while at the same time because of their supposed dependence are treated like public property. Often being denied the social privacies afforded the rest of us.

Naturally enough we are not prepared for the experience of cognitive of physical disability. We tend to assume such conditions only affect other people. Generally the initial impact of a handicapping condition is accompanied by a feeling of disbelief. Usually followed by a search for an explanation 'why me'? Many writers have drawn our attention to the fact that the newly disabled often place great emphasis upon the ordinariness of their lives before the events which led to their condition. Those who are handicapped from birth generally experience some critical incident which tells them they are different from the rest of society. (1)

For many, the transition to disability at the outset is believed to be temporary. They tend to make the unprecedented assumption that with a great deal of effort, luck and a little help from the numerous professionals that seem to surround them they will eventually return to the life they once had.

One source has estimated that there are as many as twenty three different professionals involved with the disabled individual at various times. (2) Each claiming to know what is best for them. Each professional body developing its own cognitive style of appraising the subject in question - handicapped people. Each with its in-group jargon, journals, specialist training and shared value-systems. Consequently there arises the inevitable problems of inter-disciplinary communication. Each specialist group prepares and presents its subject matter in a manner which is principally designed to give 'professional' respectability to the work itself and its members. The outcome is generally a process of mystification which is indiscernible to anyone outside that particular group. Such institutionalised mechanisms can only serve to remove the problems associated with disability away from the realms of common sense and the community. Which can only perpetuate ignorance, suspicion and prejudice. The foundations upon which discrimination against the disabled rests. In this sense then the very existence of these professional bodies is a

cause of the discrimination they seek to eradicate. Certainly professionals must shoulder much of the responsibility for the individual model of disability mentioned earlier which still dominates social policy.

Most professional bodies which surround the disabled have been the subject of someone's polemic at some time. Probably the most notorious being IVAN ILLACH's attacks on the medical profession. (3) Victor Finkelstein has argued extensively that professional bodies merely impose standards of able-bodied normalcy upon the meaning of disability for disabled people. (4) Consequently the desire for normality for the disabled individual becomes overwhelming. However daily life for the deaf, the blind, the crippled and the deformed bears little resemblance to that of their able-bodied contemporaries.

It would be almost unimaginable for most of us to comprehend living in a world of complete silence as the deaf do. A world in which the rich tapestries of sound are nothing more than a cherished memory or an incomprehensible experience seemingly taken for granted by the rest of society, where conversation is restricted to the constraints of sign language - a language which despite its immense scope is generally only understood by the deaf themselves; where communication with the rest of society largely depends upon mastery of the difficult techniques of lip reading - a method of communication with obvious limitations.

How can anyone blessed with the gift of sight contemplate the prospect of spending the rest of their lives in complete darkness. How are we to empathise with someone who can never be free of a dependence upon others for the simplest of tasks. For the blind it is a reality which can stimulate a wide spectrum of emotions ranging from resentment and isolation to complete apathy and total dependence.

Can the experience of disability be any the less devastating for the thousands of unfortunate individuals who are crippled and maimed in our factories and on our roads each year? How can anyone who is lucky enough to have good health ever understand what it feels like to be told they have contracted a debilitating degenerative disease such as Multiple Sclerosis?

The realization that one has been relegated to the ranks of the sub-normal - the handicapped, invokes a number of reactions both from the disabled themselves as well as the rest of society.

Some writers have suggested that the psychological adjustment to the realization one is disabled can be perceived as a series of psychological stages which have to be worked through. This concept is particularly pertinent to the newly afflicted due to accident or the onset of a crippling disease, but may also be applicable to children who may not realize they are disabled until they come into contact with normality, say after leaving home or special

school. One author has characterized these typologies and claims they all partially assume the individual has to pass through this sequence of stages in order to be socialized. A typical example of these psychological stages which the disabled are expected to pass through is a) shock, b) denial, c) anger, d) depression. Movement is one way, each stage has an acceptable time frame and the individual can be placed at each stage by operational criteria. (5)

Such explanations tend to neglect the importance of the family and the wider social context, adjustment inheres almost entirely in the individual and such models do not always accord with the personal experiences of many disabled people. As the work of Finkelstein and other disabled writers has clearly shown (see chapter one).

Nevertheless after the initial period of adjustment for many handicapped people the desire to appear 'normal' becomes almost obsessive. Mechanisms and devices designed to aid everyday living such as long white canes, hearing aids, wheelchairs become symbols of abnormality. Red flags which signal the need for specific reactions from the rest of society. Often stimulating in the able-bodied a variety of responses which range from extreme sympathy and pity to downright revulsion. Such reactions have a profound effect upon the process of interaction as one disabled writer has observed;-

'your status changes and with it go the privileges of independent action, and even the assumption of soundness of mind. You become a member of a recognizably different breed'. (6)

Although despite the importance of such devices it soon becomes evident that one of the most important criterion to be taken into account when assessing the value of such equipment is their unobtrusiveness. Such appliances as hearing aids, artificial limbs etc are prized not always for their functionality but their invisibility. Many disabled people deeply resent having to rely on mechanical devices. Many studies have shown the precedent we all place upon physical appearance(7) and the handicapped are no exceptions. Moreover, for the handicapped striving to achieve normality the importance of how they look becomes fundamental.

The onset of a disabling condition such as blindness, deafness or paralysis will undoubtedly transform the affected individual's life and in most cases the person affected is seen to be morally blameless. Sadly this is not the case with other less obvious handicapping conditions such as epilepsy for example.

The epileptic may have the advantage of not carrying any visible signs of disability or abnormality. Yet the psychological impact of knowing at any time he or she may experience what is commonly referred to as a 'fit' can be catastrophic. And yet according to the British Epileptic Association, epilepsy

is not a disease or an illness; -

'it is a brief disruption of the normal activities of the brain. It can affect all people of all ages, backgrounds and levels of intelligence'. (8)

Nevertheless the epileptic is still confronted with the numerous employment and legal barriers as other disabled people are. But he is often seen as tainted and unclean. The Epileptic Congress of 1977 found that the physical management of a child diagnosed as epileptic is less of a problem than the psychological damage done by the rejection of his peers. (9)

Our attitudes toward the physically and cognitively limited are such that they cannot avoid having some element of their behavioural pattern altered. In many areas their patterns of behaviours will be different from their able-bodied peers. Not simply because of their disability but because of society's attitudes toward that disability. It could be argued that the disabled individual is cast into something similar to what Talcott Parsons refers to as the 'sick role' or the 'hospital role', which according to Parsons excludes them from the normal pattern of roles. (10) They become exempt from normal responsibility, they are not expected to work. Further, because illness is seen to be socially undesirable they are expected to place themselves in the hands of those who are specifically trained to deal with such problems - what sociology refers to as 'significant others'. They are expected to give up any previous claims to status, rank or prestige they may once have had. They have no place in normal society.

However the 'sick' and the 'hospital' role is generally perceived as a temporary condition whereas the 'disabled role' is not. Consequently difficulties arise when values and expectations which may be applicable to the sick are assigned to the handicapped. As a rule, for those who are cast into the 'disabled role' the condition is permanent. Naturally enough many are reluctant to accept this position for obvious reasons. In an abstract sense they inhabit a kind of sociological no-man's land desperately trying to cling to normality while at the same time trying to distance themselves from the role into which they have been cast.

As the condition appears more permanent many become apathetic, docile and obedient. Moreover because suffering is generally associated with illness the handicapped person is often expected to endure continuous pain and discomfort without complaint. More often than not their future is relatively uncertain principally due to the fact that in many cases those who are expected to know what is best for them have little idea themselves. And they very rarely consult the disabled themselves as to what they want or feel they need.

As will be evident, the 'disabled role' is fraught with what sociologists glibly refer to as 'role stress'. That is the situation which arises when opposing and irreconcilable expectations are held about behaviour. Such conflict may arise within the individual, indeed it may be said that he or she is at war with him/her self or it may arise between him/her self and others. (11)

In many respects the concepts of role stress are applicable to us all. They can refer to the relatively trivial situations which arise in our everyday lives. For example, in my role as sociology student should I attend a particularly tedious lecture or should I in my role as only son visit my father because he lives alone and enjoys the company. Or they can refer to the more serious tensions associated with the complexities of life in modern society such as the serious stress and strains experienced by many women who are trying to run a home, bring up children and hold down a steady job. But for most of us role stress is a relatively temporary nuisance. For the disabled role stress is an almost permanent fixture in their daily lives. Because of the wide variety of attitudes and responses the handicapped person stimulates in others he or she must be prepared to adapt his or her behavioural patterns accordingly at any social encounter at the drop of a hat.

As I mentioned earlier the importance of physical appearance is fundamental particularly at the initial stages of social interaction.

Consequently for those whose disabilities or abnormalities are easily visible the process of interaction can be distinctly traumatic. During the 1950s Erving Goffman made an extensive study of the process of interaction between the normal and the abnormal. In his 1963 analysis 'Stigma' he articulates beautifully the numerous, varied and often elaborate strategies those people who are normally perceived as abnormal are prepared to go through in order to achieve social acceptance by the rest of society. For Goffman the physically and cognitively impaired are among those groups in society who along with ethnic minorities, religious groups and social deviants are seen to be less than human. Such people Goffman claims are stigmatized. They are shunned and rejected by the rest of society. The unfortunate individual becomes what he refers to as a 'shamed person'. Moreover it is the disgrace he believes rather than the affliction which causes the stigma. The result being that the bearer's rank and status are radically reduced thus subordinating him to the rest of society. As a consequence of this stereotype the stigmatized person is forced to resort to one of a wide variety of elaborate techniques of concealment, distortion and in many cases elaboration in order to secure some measure of social acceptance and shore up his precarious social predicament. (12)

While it can be argued that the disabled role is located within Goffman's concept of stigma there are significant differences between the disabled individual and the 'shamed person' Goffman talks of. To begin with whereas society's perceptions of ethnic or religious minority membership are subject to



change. For example the Jewish community has been largely successfully integrated into contemporary British society and overt anti-semitism is a thing of the past. The same can also be said of many forms of social deviance again homo-sexuality affords an excellent example. The same cannot be said of society's attitude toward the handicapped. Further his assertion that it is the 'sense of disgrace' which causes disabled people to resort to mechanisms of distraction etc is largely incorrect in my view. Most disabled people I believe do not inherit a sense of disgrace with their disability. They employ such tactics as Goffman describes not because of a feeling of guilt or shame but simply because they have to, in order to overcome the enormous social and institutional barriers society has erected between them and normality.

However, as Goffman observes how the handicapped present themselves to the rest of the world can vary enormously. Some will appear totally uninterested in themselves, their condition and their future. Often refusing to communicate with anyone they are not familiar with. Sometimes bowing their heads in order to avoid eye contact as if acknowledging their supposed subservience. Others may develop socially irritating habits; - stammers or twitches due to feelings of nervousness and insecurity. Further compounding their overt awkwardness, which makes the possibility of anything resembling normal social interaction between them and the ordinary man in the street that much more difficult.

For those who have been subjected to long periods of institutionalization the process of interaction with other members of society can be particularly traumatic. Simply due to their lack of experience in the outside world. As a consequence of this lack of experience many disabled individuals often appear unusually naive, child-like and overtly affectionate. For example, some disabled people not used to the standards of behaviour in contemporary society often feel the need to make some form of physical contact during the process of interaction. This may take the form of kissing, embracing or grabbing hold of the other's arm. Because such actions are normally outside the realm of social contact particularly for casual encounters and relationships, they are often misunderstood by ordinary people.

After long periods of separation from 'normal' society some handicapped people become extremely sensitive and easily hurt. While others appear belligerent, argumentative and withdrawn. And yet despite the emotional and physical barriers to integration many cognitively and physically limited individuals seem determined to live as normal a life as possible. Our society is quick to acknowledge the achievements of those who successfully apply the necessary modifications to their behavioural pattern and adapt to the role ascribed them. They become symbols of strength and virtue. Disability for some can often expose untapped reserves of skill and determination enabling them to integrate successfully back into the community. Indeed in some cases others appear to capitalise upon their new social identity. However, this form

of sanctification of which our society is prone only serves to compound the feelings of inadequacy for those who feel they are unable to make the grade.

However what is clear is the fact that the individuals in question have had to substantially re-structure patterns of behaviour. Not simply because of the disability itself, but because of our society's attitudes toward them because of that disability. But although there are extensive variations between the patterns of behaviour of handicapped people I believe it is possible to divide them into three distinct groups.

A) Aggressively autonomous disabled role. Refers to those people who cannot come to terms with their ascribed social identity. They try desperately to hold on to their independence often to their cost. Refusing all legitimate forms of help and advice. They can appear resentful, lethargic, withdrawn and alienated. They are dominated by the injustice of reality.

B) Completely dependent disabled role. Concerns those disabled people who appear to have given up all claims to any form of social identity other than being a disabled person. They accept their subordinate position totally. They are unwilling to do anything for themselves. They often appear immature, apathetic and are seemingly incapable or unwilling to accept any degree of responsibility

C) Normative disabled role. Refers to those groups of people who have adjusted to their social position reasonably well. It may be said they are making the best of a bad job. They accept, albeit reluctantly, their subordinate social status and adapt accordingly. They are undoubtedly the most successful in coming to terms with their condition. (The above are generalizations based upon the research I have conducted to date.)

The degree of variance within the disabled role does not in my opinion depend solely upon the level of disability incurred by the individual. There are several instances of people overcoming enormous difficulties leading as normal a life as possible. (13) While others seem completely incapacitated by what may seem a relatively minor complaint. What seems clear is that how people react to a disability generally depends upon several extraneous factors such as familial support, economic resources, social class education and so on. Nevertheless, however well the physically and cognitively limited cope with their condition the fact remains that they are seen as disabled first and human beings second.

Furthermore as a consequence of the strategies of exclusion to which our society seems committed, the able-bodied are equally ill prepared for the intricate processes of social interaction with the less fortunate.

As a result of the stereotyped normality which still pervades modern society

contact with the physically or mentally abnormal is for most of us an experience to be avoided. How many of us when confronted by a severely deformed adult or child can stifle an automatic compulsion to turn away or stare helplessly at the often emotionally disturbing inequalities of fate? Or who amongst us when meeting two people, one obviously handicapped do not automatically address any conversation to the more 'normal' of the two? How when our society systematically separates the disabled person from the normal are we expected to cope with the distinct emotional dilemmas which so often engulf us at the point of social contact? It is hardly surprising in the light of such realities that the process of social interaction is so difficult.

In a society where discrimination and segregation are generally the rule rather than the exception normal social relations between the able-bodied and the physically and mentally impaired will remain on the whole a major problem. As a consequence of the unfamiliarity which exists within the two groups, neither is equipped with the necessary social repertoire that is essential if integration is ever to become 'normal'.

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## 6. Conclusion

My objective throughout this essay has been to bring to the attention of sociology one of the most consistent and complex features of all known human societies, namely discrimination against the physiologically and cognitively less able. The systematic separation of the handicapped from normal everyday society has meant that they and the enormous difficulties, both social and economic, which they encounter in the course of their daily lives are generally outside the boundaries of our consciousness. To a large extent this also applies to many sociologists. They too have tended to overlook the handicapped members of society, both as individual social actors and as a social group. This in my view is a fundamental mistake. As this essay has shown, the majority of the problems associated with physical and mental disabilities are socially constructed and as such are the legitimate subject matter of this discipline.

As is customary with any discussion of this nature the opening chapter began with a brief reiteration of several of the innumerable attempts to formulate an adequate definition for disability. They included functional, professional and two of the personal definitions of handicap articulated by the disabled themselves. It will be evident from this admittedly limited discussion that to some degree all have proved relatively unsatisfactory - here I hasten to add I include that used by myself for the purposes of this analysis. Consequently part of the argument here must be that definition of such a complicated subject is not possible. Indeed many writers have drawn our attention to the fact that it is in the interests of the cadres of professionals which surround the disabled to ensure that disability is clearly defined, but how often do such descriptions concur with personal ones, and are those intent upon such practices aware of the stigmatizing effect being labelled a disabled person can have upon an individual? Nevertheless the fact remains that there are many elements within society which demand classifications and while the idea of labelling people may be repugnant to many, for the physically and mentally less able it is a reality they have to accept - if only to qualify for the specialist help and benefits they so desperately need.

It is clear from the brief historical analysis outlined in chapter two that discrimination against this group of people has existed to some degree in almost every known human society, and while it may be true to argue that the more extreme forms of discriminatory action that have been synonymous with earlier 'less enlightened' periods of our history, have largely disappeared, subordination, rejection and segregation for the handicapped in the modern epoch remains an unwelcome reality. Certainly the spread of Christian morality which arose during the nineteenth century did not dispel the ignorance and superstition which still surrounds physical and mental inadequacies. The upsurge of liberal society merely changed the forms discrimination took - they became institutionalized, incorporated into the

mechanisms of the state. The structural barriers to integration which remain serve to perpetuate this ignorance and prejudice, and while it could be argued that the treatment afforded the physically and cognitively impaired during earlier periods of history can be justified and understood by their reliance upon mysticism and the supernatural for explanation, the same cannot be said of contemporary society.

As chapter three makes abundantly clear the humanitarian principles to which our society claims allegiance are extended only to those who are fortunate enough to be perceived as physically or mentally 'normal'. Furthermore, while it may not be correct to argue that modern society actually causes disability, despite the often crippling effects of modern industry, the catastrophic misuse of drugs - both legal and otherwise - and the seemingly uncontrollable spread of pollution, it certainly exacerbates the problem. The social and economic deprivation to which the handicapped are subjected in modern society compounds the feelings of social inadequacy that physiological or cognitive limitations or abnormalities often produce.

The consequences are such that as soon as an individual becomes seen as a 'disabled person' their subsequent life chances are drastically reduced, not only economically but socially. They become marginalised, they are thought of as dependent, a burden upon the rest of society and as a result quickly begin to see themselves as such. They have no culture or sub-culture into which they can retreat as other minority groups often do, they are completely alienated from the rest of society. Their personality is dramatically altered, as Erving Goffman observed they become 'managers of a spoiled identity'! They are forced into what I have referred to as the 'disabled role' - a role fraught with continuous trauma and contradictions - a role distinct from any other.

The behavioural pattern associated with the disabled role can be subdivided, as I have shown, into three separate groups, each with its own dominant characteristics, and although the onset of a disabling illness or crippling accident may partially explain the initial feelings of inadequacy and depression which are experienced by those affected, they do not explain the long term debilitating effects of being labelled 'disabled', nor do they explain why there is such a variety of responses to this condition.

Medical conditions alone cannot stimulate such a fundamental change in self-perception which effects these people. Furthermore, while psychological explanations have proved useful, to date they have proved inconclusive in isolating the principal causes of this phenomenon.

It is clear then, that the devastating consequences of the onset of a disabling condition are on the whole socially produced and as such it is sociology alone which can offer a satisfactory causal explanation, both for the persistence of society's generally negative attitudes toward the handicapped and the effects

these attitudes have upon the disabled as a group and as individuals. Indeed through a systematic empirical analysis of the three types of disabled role and the social relations which surround them, such as class, family and so on, it may be possible for Sociology to provide the clues and insights which can help to eliminate their more extreme dimensions. Moreover, if we are ever to abolish the ignorance and superstition upon which discrimination rests then it is Sociology which must provide the necessary understanding if real integration for disabled people is ever to become a reality.

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