**Chapter 1 (In 'Cabbage Syndrome': The social construction of dependence, Colin Barnes (1990) The Falmer Press, pp. 1-16)**

Introduction

Background

The initial impetus for this study stems from three distinct but related factors. The first is my interest in the general economic and social disadvantage associated with disability, in particular the experience of young people with physical impairments (highlighted by Anderson and Clarke, 1982; Brimblecomb *et al.,* 1985; Cantrell *et al.,* 1985; Hirst, 1984, 1987; Hurst; 1984; Kuh *et al.,* 1988; Lones, 1985). A second is the substantial critique directed toward those people who are employed professionally or otherwise, in the rehabilitation or caring industries. In broad terms these arguments suggest that professional intervention compounds disability because it inhibits individual adaptation and induces dependence (see, for example, Davis, 1984; Finkelstein, 1980; Oliver, 1983a; and Scott, 1970). In conjunction with these censures there has emerged from some sections of the 'disabled' population an increasing demand for self-advocacy and self-determination in institutional settings which cater for people with impairments (Crawley, 1988; Dartington *et al.,* 1981; Davis, 1985, 1986; Oliver, 1983a, 1986, 1987a; Sutherland, 1981; and UPIAS, 1976, 1981).

While the positive effects of this movement are undoubted in terms of consciousness-raising, I believe it is essential that these developments are situated within an appropriate context to prevent their lending weight to those who would justify the erosion of state-sponsored welfare provision within the logic of utilitarian individualism and economic rationality. In order, therefore, to offer informed comment upon these debates with any degree of authority, it is important to conduct research located within an environment where the impaired and their accredited 'helpers' interact on a regular daily basis.

Probably the most obvious and arguably the easiest location for a study of this nature, if only because of its convenience, would be the archetypical residential institution specifically catering for a particular group of impaired people in which the avowed ideology is unequivocally therapeutic and rehabilitative and where there is a clear line of demarcation between the helper and the helped in terms of both role and function. Since the 1950s

there has been increasing attention focused on this type of establishment by both social scientists and inmates.

Writers focusing on the incarceration of the physically impaired include Battye (1966), Hunt (1966) and Miller and Gwynne (1972), notwithstanding that the majority of this work has been concerned with institutions serving the mentally ill and handicapped (see, for example, Barton, 1959; Bloor, 1987; and Goffman, 1961).

While these studies have made an invaluable contribution to the understanding of the interdependence of the helper and the helped within residential settings they are limited in that their conclusions may only be applicable to the experiences of those who live and work in closed systems. It can be argued that they have little or no bearing upon the realities of daily life for the countless thousands of individuals with impairments who live within the local community, nor for that matter for the service providers upon whom they are said to depend.

This is particularly relevant to the experience of disability in Britain in the 1980s since 93 per cent of people with impairments now live in their own or their family's home (Martin, Meltzer and Elliot, 1988). This trend is partly due to the media exposure of the harsh realities of life in many residential institutions, the innumerable public outcries over conditions in some long-stay hospitals (Brown, 1980), the development of sophisticated drug therapies and a realization by policy-makers generally that prolonged incarceration for large numbers of the population does not make sound economic sense (Jones *et al.,* 1983). Consequently successive government statements on this issue since the 1950s have underpinned the idea of care within and/or by the community (Bulmer, 1987).

In response to this growing awareness by central and local government there was a large expansion during the 1960s and early 1970s of an assortment of services designed to facilitate independence and care in the community for people who hitherto had been confined to an institution (Parker, 1985). These services include increased numbers of general practitioners, district nurses, home helps, sheltered housing schemes, hostels, training centres, workshops and day centres. Despite this growth, provision has not been able to keep pace with consumer demand (Jones *et al.,* 1983) and the quality and allocation of services was, and remains, subject to regional variation (Griffiths, 1988). Moreover, due to the emphasis placed on financial constraints by the present Conservative government there is a very real danger that some of these services might

disappear without proper evaluation (see Redding, 1989). One of the services increasingly under threat is the day centre run by the Social Services Department of the local authority.

Day centres are a relatively new phenomenon and as such have received little or no attention from social analysts, with the notable exceptions of Carter (1981, 1988), Kent *et at.* (1984), Jordan (1986), Symonds (1982) and Tuckey and Tuckey (1981). It is often stated that there is a particular need for this type of service for young people with impairments who have finished formal education and are unable to find work.

Much of the literature, however, is critical of the existing systems of day centre provision with regard to the needs of this particular user group. Most centres emphasize care rather than promoting young people's control over their own lives and their participation in ordinary adult society. Moreover, many day centres for the physically impaired are used predominantly by elderly people with chronic disabilities and offer little scope to young adults for peer contact and stimulation (Kent *et al.,* 1984). In short, for young people with physical impairments, most day services are criticized as precluding rather than promoting personal development, independence and self-esteem. This is particularly alarming since young people with physical impairments generally expect to establish an independent life of their own in much the same way as their non- impaired contemporaries (Parker, 1985).

This climate of opinion provides the starting point for the present study. It highlights the necessity for investigating how day centre provision is understood by both users and providers as a basis for furthering the limited knowledge of its dynamic, commenting upon the critique concerning the interactions between the helper and the helped, and formulating policy recommendations towards the system's improvement. I believe the latter to be a principal concomitant for all social analysis and broadly in line with the traditional view of social science recently elaborated by Heller (1987). In order to avoid what may be termed a theoretical vacuum, it is important that this research encompass both the empirical and the theoretical dimensions of the issues at hand by locating the empirical within the theoretical. Hence, it is essential to explore initially the principal sociological approaches to the subject of disability.

A preliminary task is to clarify the terminology used in the subsequent discussion. The following typology was developed during the 1970s and adopted by the World Health Organization in an effort to minimize the

complexities of definition. It distinguishes impairment, disability and handicap.

*Impairment*

This refers to an anatomical or psychological disorder which is defined symptomatically or diagnostically. Impairments may affect locomotion, motor activities or sensory systems and be medically based or of psychological origin. They may involve any loss of physiological, psychological or anatomical structure or function. Such limitations can be permanent or temporary, present at birth (congenital impairments) or acquired later in life (adventitiously). Impairment is generally regarded as a neutral term.

*Disability*

This normally refers to the impact of impairment upon the performance of the basic elements of everyday living such as walking, negotiating stairs, getting in and out of bed, dressing, feeding, communicating with others, holding down work, etc. The term disability is used when an impairment is objectively defined and constitutes a restriction on mobility, domestic routines, occupational and communication skills.

*Handicap*

A term which has widely come to represent the most profound effects on impairment and disadvantage which implicate the whole person and not merely selective incapacities. Handicap in children has been seen as an impairment or disability which for a substantial period effects, retards, disturbs or otherwise adversely affects normal growth, development and adjustment to life. In adults, handicap constitutes a disadvantage for a given individual in that it prevents or limits the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual. The designation of handicap involves a value judgment.

The relationship between these three concepts is not direct but related to a number of ill-defined notions which, for reasons discussed later, are beyond the scope of the present study. However, they may be expressed diagrammatically as shown in Table 1.

*Table 1      Disablement Experience Summarized*

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| Impairment | Intrinsic situations exteriorized as functional limitations |
|---|---|
| ↓ | |
| Disability | Objectified as activity restrictions |
| ↓ | |
| Handicap | Socialized as disadvantage |

*Source: Bury, 1979*

Sociological Approaches to Disability

When discussing sociological perspectives on disability it is generally regarded as fruitful to begin with the work of Parsons and his analysis of sickness-related behaviour. This is because the Parsonian paradigm has been principally responsible for two distinct, but interdependent, approaches which have implicitly or explicitly influenced all subsequent analyses. They are the relevance of the 'sick role' in relation to disability and its association with social deviance, and the notion of health as adaptation (Bury, 1982). In short, Parsons' model suggests that at the onset of illness the sick person adopts the sick role. Rooted in the assumption that illness and disease impede physiological and, to some degree, cognitive abilities, the individual concerned is automatically relieved of all normative role expectations and responsibilities. S/he is not accountable for the malady, nor is s/he expected to recover through an active decision of free will or subjective action alone. Hence, s/he is expected to seek help, invariably professional medical help, in order to regain her/his former status. The sick person is encouraged to view her/his new-found status as undesirable and abhorrent (Parsons, 1951).

The Parsonian model is limited in the sense that it assumes that regardless of the nature and type of disease, or the subjective socio/psychological factors involved, everyone will behave in exactly the same way at the onset of illness. Moreover, since the model pays little heed to subjective interpretations, it articulates only the views of the representatives of society credited with the responsibility for recovery, namely, the medical profession. It does not accommodate sick role variation (Twaddle, 1969) nor the distinction between illness and impairment (Gordon, 1966) nor

sickness expectations related to the illness and not the actor (Kassebaum and Baumann, 1960).

Occupation of the sick role is intended to be temporary. But for the chronically sick or for a person with an impairment there is little scope for recovery in terms of being restored to her / his former physical state, and because the 'disability' is part of her/his existence, the disabled person begins to accept the dependence prescribed under the sick role as normal. The sick role, therefore, removes from the impaired individual the obligation to take charge of her/his own affairs and sustains this on a more or less permanent basis (De long, 1979).

These general criticisms are elaborated within the context of the' impaired role' as discussed by Gordon and by Sieglar and Osmond. Their alternative construct is applied to the actor whose condition is unlikely to improve and who therefore is unable to comply with the first prerequisite of the sick role model, that is, to try to recover as quickly as possible. It is claimed that those who accept the impaired role have abandoned all thoughts of rehabilitation and have largely accepted the notion of dependency as permanent. Thus

> a person who fails to maintain the sick role may find himself in the impaired role, unlike the sick role the impaired role is easy to maintain and difficult to leave for it is meant to be permanent, but it carries with it a loss of full human status. It is true that the impaired role does not require the exertions of co-operating-with medical treatment and trying to regain one's health but the price for this is a kind of second class citizenship (Sieglar and Osmond, 1974, p. 116).

Dejong (1979) has suggested that the impaired role is not a normal role, but one that a disabled person is allowed to slip into as the passage of time weakens the assumptions of the sick role.

A further variation in the this train of thought is the 'rehabilitative role', as articulated by Safilios-Rothschild (1970). This model implies that once the impaired actor becomes aware of her/his new condition, s/he should accept it and learn how to live with it. This can be achieved, it is claimed, through the maximization of her/his remaining abilities. Thus the actor is obligated to assume as many of her/his previous normative roles as quickly as possible. S/he is therefore not exempt from social expectations and responsibilities but is expected to 'adapt' accordingly. Moreover, it is also assumed that not only will the impaired actor co-operate with the

rehabilitative professions but will innovate and: ameliorate new methods of rehabilitation.

In accord with this construct, the locus of responsibility rests squarely upon the shoulders of the impaired individual and, again, s/he is evidently dependent upon others, notably the rehabilitation professionals, for at least two specific functions - the initiation of rehabilitation programmes designed to return the impaired actor to 'normality' and assistance in the psychological adjustment to the new (disabled) identity. Some writers have suggested that the psychological adjustment to the realization that one is impaired can best be understood as a number of psychological stages, including 'shock', 'denial', 'anger' and 'depression', which the impaired actor must pass through before s/he can accept her/his new-found status. Movement is generally seen as only one way and as sequential. Passage through each stage is usually determined by an 'acceptable' time frame according to professionally agreed criteria (Albrecht, 1976).

In ideal typical form, all psychological theories of adjustment can be criticized on at least three different levels. The first is that they are essentially determinist. Behaviour is only viewed as positive if it is compatible with the consensual view of professional reality. Secondly, they pay little heed to extraneous economic, political or social factors. Thirdly, they ignore subjective interpretations of impairment from the perspective of the actor concerned. They are the products of what one critic has referred to as the 'psychological imagination', constructed on a bedrock of able-bodied assumptions of what it must be like to become impaired (Oliver, 1983a). Moreover, impairment is presumed to involve some form of loss, or personal tragedy. Consequently recent literature dealing with the traditional, medical or individual model of disability, has begun to refer to these formulations as 'personal tragedy theory' (Oliver, 1986).

An important factor which must be considered when assessing the logic behind the ideological hegemony of personal tragedy theory is its professional expediency, both at the individual and at the structural level. For example, if an impaired person fails to achieve the anticipated professionally determined rehabilitative goals, then that failure can be explained away with reference to the impaired actor's perceived inadequacies, whether they be physiologically or psychologically based. The 'expert' is exonerated from responsibility, professional integrity remains intact, traditional wisdom and values are not questioned, and the existing social order goes unchallenged.

The relationship between disability and deviance can be understood with reference to the freedom from social obligations and responsibility, explicit in the sick role model and subsequent derivatives and in the negative views of illness, disease and impairment that continue to hold sway throughout all modern industrial capitalist societies. Because such societies are founded upon an ideology of personal responsibility, competition and paid employment, any positive associations with sickness or disability, such as the exemptions outlined above, must be discouraged, particularly since they may appear attractive to those already disadvantaged, both economically and socially, by their structural location.

Indeed, the analysis of social reaction toward disadvantaged minority groups such as the disabled became a central focus for sociologists working within the traditions of symbolic interactionism during the 1960s. With their emphasis upon meaning, identity and the process of labelling, interactionists explored the relationship between disablement and socially proscribed behaviour. Initially theorists working within this perspective were interested in the areas of crime and drug addiction, but after substantial ethnographic research turned their attention toward the mechanisms by which these and other forms of human activity were shown to be socially unacceptable. Becker, for example, stated that

> Deviance is not a quality of the act a person commits, but rather a consequence of the application by others of rules and sanctions to an 'offender'. The deviant is one to whom the label has successfully been applied, deviant behaviour is behaviour that people so label. Deviance is not a quality that lies in behaviour itself but in the interaction between the person who commits an act and those who respond to it (Becker, 1963, p.9).

Lemert (1962) made a further distinction between 'primary' and 'secondary' deviance, the former having only marginal implications for the actor in question and the latter relating to the ascription by others of a socially devalued status and a deviant identity. Secondary deviance for Lemert becomes a central facet of existence for those so labelled, 'altering psychic structure' and producing specialized organizations of social roles and self-management. Goffman (1968) developed the idea further with his use of the concept 'stigma'~ a term traditionally used to refer to a mark or blemish that is reputed to denote 'moral inferiority'. Goffman suggests that the stigmatized, such as 'the dwarf, the blind man, the disfigured, the homosexual and the ex-mental patient' are viewed by society at large as

not quite human. The application of a stigma is the outcome of situational considerations and social interactions between the 'abnormal' and the 'normal'.

Within the context of these developments, impaired writers, first in America and then Britain, began to challenge the orthodox wisdom that underpinned the traditional approaches to rehabilitation and social provision in general. Scott (1970) questioned the type of 'deviance creation' that resulted from the interactions between the impaired and the acredited expert. In his study of 'blindness workers' in the USA Scott claims that these workers make 'blind men' out of people who can't see by imposing blindness-related behaviour patterns and attitudes which conform to the expert's view of blindness on people with sight problems. For Scott this represents a form of socialization in which the impaired individual is coerced into accepting a dependent subordinate role, concomitant with' normal' perceptions of disability.

Throughout this period other writers adopted a more conventional approach to the study of disability. Haber and Smith (1971) argued that we should focus rather on the elaboration of behaviour alternatives within existing role relationships, rather than the proliferation of 'specialised role repenoires'. In this way the behaviour of the disabled may be normalized. It may not therefore, constitute secondary deviance.

This idea was developed further, although within the rubric of American radicalism, by Anspach (1979), but more in keeping with the work of Merton (1957) than Parsons, Anspach developed a four-dimensional model titled 'Strategems of Disability Management', which he claims typifies the modes of adaptation generally used by impaired individuals in response to society's overly negative attitudes toward disability. The first he calls the' normalizer', where the actor labelled' disabled' accepts and concurs with societal estimations of her/himself, and behaves accordingly by seeking acceptance at any price. The second is ' disassociation' , where the individual accepts the wider cultural interpretation of disability but is unwilling, or unable, to accept it with regard to her/himself. As a result s/he has a lowered perception of self. Social interaction is avoided since it only serves to reinforce negative self-concepts. The third, 'retreatism', is almost identical to the Menonian concept of the same name. Consonant with negative perceptions of society and self, the individual rejects the wider cultural views of disability and has little or no self-esteem. Withdrawal, from all social activity is, therefore, the preferred pattern of behaviour. The fourth

is the 'political activist', which is the construct favoured by the author. He writes:

> like the normalizer the activist seeks to attain a favourable conception of self, often asserting a claim to superiority over normals. But unlike the normalizer the activist seeks to relinquish any claim to an acceptance which *s/he* views as artificial (Anspach, 1979, p. 770).

Although orthodox in its construction, Anspach's formulation does serve to highlight the radicalization of some factions of the disabled population within American society during the late 1960s and early 70s. What became known as the Movement for Independent Living (ILM) emerged partly from within the university campus culture and partly in consequence of the efforts of some enlightened professionals to influence American legislation with regard to issues. pertinent to people with disabilities. One of the movement's principal protagonists, De Jong, challenged the validity of the medical model, notwithstanding that he gave tacit approval to Safilios-Rothschild' s construct, the rehabilitation role, arguing that disability was in large part a social construct and that environmental factors were at least as important as impairment-related variables in the assessment of the degree to which a person is able to live independently. De long claimed to be establishing a new paradigm in the celebrated tradition of Kuhn, by which the current body of knowledge and thinking on disability would be rendered obsolete. De Jong's paradigm shift heralds what later became known as the 'social model of disability' as opposed to the traditional perspectives associated with the medical model, psychology and the sick role variations (De Jong, 1979).

This approach and the activities of the ILM are, however, firmly entrenched within the philosophical and political traditions which De Jong refers to as 'radical consumerism'. In his estimation this was the driving force behind other major political movements which swept the USA during the same period. It is not surprising, therefore, that the ILM is wedded to the principal assumptions that form the ideological cornerstones of capitalist America, such as economic and political freedom, consumer sovereignty and self-reliance. The movement's avowed aim is to facilitate the reclamation of disabled people's subjective autonomy through opposition to what they see as the professionally dominated, bureaucratically inert state monopoly of welfare provision (in the American Federalist sense), through rational and competitive pursuit of the interests of the disabled in the political and economic marketplace.

Writers working within this paradigm tend to heap all their polemic upon the rehabilitation professionals and what they consider to be excessively bureaucratic administration. Whereas personal tragedy theory over-emphasizes subjective physiological and cognitive limitations through the professionally determined functional definitions of impairment, .social reaction theory' challenged the authenticity of those definitions, but generally ignored the structural factors which may have necessitated or precipitated their application. While much attention is directed toward professional ineptitude and maladministration, little is paid to the structure itself. Such a position tends to ignore history and the stark inequalities of the free market economy.

State-sponsored welfare systems emerged as a necessary response to the fact that in the free expression of the market, people's needs were not being met through no fault of their own. Because the ILM is wedded to the notion of free competition it tends to favour particular sections of the disabled population, namely, young, intellectually able, middle-class white Americans (Williams, 1984). In addition, it is particularly suited to an achievement and self orientated culture which may allow for society the further disavowal of any responsibility (Blaxter, 1984).

Whereas personal tragedy theory lends itself to what has come to be regarded as unacceptable levels of paternalistic control and welfarism, social reaction theory implies a return to a free market economy which favours only the most able. While it may be argued that the latter marks something of an advance on the former, since it shifts the onus of responsibility for disability away from the individual and acknowledges the social construction of the disability category, it offers little by way of an explanation as to the reasons for its creation.

An attempt to resolve this problem can be found in the work of Stone (1985), who argues that all societies function through a complex system of commodity distribution, the principal engine of which is labour. Since not everyone is able, or willing, to work, a second system of distribution comes into play, a system based on perceptions of need. She maintains that disability assessments are not made on medical or clinical judgments alone, but on political considerations also. Thus the disability category is a social construct. The medicalization of disability is explained with reference to the accumulation of power by the medical profession and the state's need to restrict access to the state-sponsored welfare system.

A more radical approach has been adopted by a number of writers who are themselves impaired (notably Abberley, 1987; Finkelstein, 1980, 1990; and Oliver, 1983b, 1986). By utilizing an essentially materialist evolutionary model, Finkelstein contends that for Britain at least, history within the modern epoch can be divided into three distinct sequential phases. The first broadly corresponds to the feudal period immediately prior to industrialization where economic activity consisted primarily of agrarian or cottage-based industries. This mode of production, he claims, did not preclude the impaired from participation in the economic life of the community. But in phase two, when the process of industrialization took hold, the impaired were systematically excluded from the new production methods on the grounds that they were unable to keep pace with the 'disciplinary power' (Foucault, 1977) of the factory. Disabled people were therefore segregated from the mainstream of social life and incarcerated within large-scale institutions and asylums, which also appeared throughout this period (Scull, 1978, 1984). Finkelstein's third phase, which is only just beginning, will see the eventual liberation of the impaired from this form of discrimination through the development and eventual widespread utilization of modern technology, and the working together of the impaired and the rehabilitative professionals toward commonly held goals (Finkelstein, 1980).

For Finkelstein, disability is a paradox involving the individual with an impairment and the restrictions imposed upon her/him because of that impairment by society. Through the adoption of this three-stage historical model he demonstrates how this paradox only emerged during the period of industrialization in phase two. In phase one the impaired were dispersed throughout the community as pan of the underclass, but in phase two they became segregated. Disability became a special category and as such was understood to involve individual impairment, and social restriction (Finkelstein, 1980) .

It has been noted that available historical evidence does not substantiate this scenario in graphic detail, but temporal accuracy was not Finkelstein's prime concern. He used this model as a heuristic device to demonstrate the social nature of disablement and focus attention on both the economic and political considerations which contributed to contemporary British attitudes toward impairment and the meaning in which professional attitudes and those of the impaired themselves are shaped by these considerations (Oliver, 1986).

It is 'professional/client' interaction, referred to as the helper/helped relationship, which, he contends, plays a crucial role in structuring the consciousness of the individuals concerned.

> The existence of helpers/helped builds into this relationship normative assumptions 'if they had not lost something they would not need help' goes the logic, and since it is us the representatives of society doing the help, it is society which sets the norms for the problem solutions (Finkelstein, 1980, p. 17).

For Finkelstein the rise of 'able-bodied' assumptions in phase two represents a major transformation in which relations with the impaired were conducted. Personal tragedy theory is built into these relations. It is suggested that when helpers take on board the normal assumptions of the helper/helped relationship, it is inevitable that they will inculcate the helped with these assumptions. Therefore, for Finkelstein, disability is defined as a specific form of social oppression that is faced by people who are in some way impaired.

While in broad agreement with this view, Oliver (1986) has pointed out that it is difficult to see why oppression with regard to disabled people is special. Since all social relations in capitalist society are synonymous with oppression, one class oppresses another and disabled people are nothing if not pan of the oppressed class. But such contentions are difficult to substantiate since it is unequivocal that disability is 'no respecter' of race, sex or class (Thomas, 1982) and apart from one or two notable exceptions, such as Townsend's *Poverty in the United Kingdom* (1979), analyses which establish the links between disability and social class are few and far between. There is also considerable variation in the degree of oppression experienced by different elements within the disabled population, some of whom are more disadvantaged than others. Moreover, some people with impairments consider themselves neither oppressed (Goldsmith, quoted in Oliver, 1983b) nor disabled (Blaxter, 1984).

Oliver does, however, take up a theme which is clearly visible throughout the bulk of the literature associated with this subject when he asks why most social provision to date has tended to reinforce the dependency of people with disabilities rather than make them more independent. This is one of the main questions I hope to answer in this study, particularly with regard to day services for the younger physically impaired.

General Outline of the Study

Because of the relative absence of detailed empirical accounts of the daily interactions between helpers and helped within the context of the day centre environment, the temporal constraints of the research design, and a subjective preference for the ethnographic method of enquiry, the choice of methodology for this study was mainly interactionist. It is often pointed out that because of its consistent failure to link interpersonal relations with the material base upon which they occur, this type of investigation can never provide anything other than descriptive, but colourful, accounts of a given sequence of events or particular phenomenon. This type of research should, and invariably does, however, form the basis upon which much sociological theory is constructed. This study, therefore, is intended as an implicit, if not explicit, plea for the further development of the social oppression theory of disability. A detailed discussion of the methodology used in this study appears in Chapter Three.

Before proceeding, it may be appropriate to reiterate the primary objectives of the study. They are, firstly, to describe and evaluate the role of the day centre within the local community with regard to provision for young adults with physical impairments; secondly, to describe and evaluate the interactions between the users and staff within the context of the day centre environment; thirdly, to outline and assess the level of user participation within the centres with regard to activities, the decision-making process and control; and lastly, to formulate a list of policy recommendations based upon the findings of this research.

In order to fulfil these objectives I discuss in Chapter Two the socio/economic origins of societal oppression of people with impairments and their systematic segregation and incarceration during the nineteenth century and the first half of the twentieth century. Due to the rapid growth in the numbers of people termed 'disabled' in the 1950's, coupled with the rising cost of institutional care, a number of policies, including day centres, were developed to help people with impairments stay within the community and remain independent. Although day centres became fairly common in Britain in the following two decades there is no consistent or coherent national policy regarding their primary role.

Using Dartington, Miller and Gwynne's (1981) analysis of interactions between the impaired and the non-impaired, four ideal types of day centres for the young disabled are identified. They are the 'warehouse', 'horticultural', 'enlightened guardian' and 'disabled action' models. All are criticized on the basis that they are inherently segregative, emphasize

difference and perpetuate stigma. Within this context day centres are perceived as the 'dumping grounds' for people who are excluded, because of impairment, from the normal economic and social life of society.

Empirical evidence to support this view is provided, firstly, by the overtly negative features of the general organization and admission policies of day centres; Secondly, by the degree of social and economic disadvantage experienced by the users interviewed prior to day centre use; and thirdly, by the manner in which they were similarly labelled and 'directed' toward the centres, despite the diversity of their individual impairments. In addition, I shall argue that day centre use reinforces disadvantage because, although helper/helped relations within the centres are generally viewed positively by both users and staff, user participation and control of services is low; and, while the system provides a range of facilities which give many users a degree of self-determination unavailable in the surrounding area, its capacity to extend those experiences beyond the day centre boundary is limited to only a few. Consequently for most attendance will be long-term.

The argument is substantiated with reference to the relatively recent and' ad hoc evolution of provision for the younger physically impaired which was known as the Contact group in relation to day services generally. The data in Chapter Four show that Contact developed as a result of the protracted and complex interactions between external and internal forces, including the established traditions of day services in the local community, the limited resources available for younger users, the social characteristics of both Contact users and staff and the subsequent relations between the two groups within the Contact framework.

The three centres in which the Contact groups was located were well established and catered for a number of other disadvantaged groups, predominantly the elderly impaired. The service generally had evolved along 'traditional' lines, incorporating an ideology of 'care' and explicitly social activities, exemplified by the phrase 'tea and bingo', broadly in keeping with the 'warehouse' model discussed in Chapter Two. Contact emerged in response to locally perceived need. There was relatively little direction from the local authority social services department or other agencies concerned with disability regarding what facilities the new service should provide. As a result Contact developed along different lines from those of existing provision. For example, it provided a five-day service, used three day centres rather than one and had its own permanent staff. These factors led to higher levels of social and professional interaction

between users and staff which are generally regarded as positive by both groups.

In contrast to earlier studies concerned with day services it was evident that the level of professional qualification and experience among senior day centre personnel was relatively high, but that this level of training was not apparent with reference to the care assistants (CAs), most of whom were on or had been recruited through government-sponsored youth training schemes. Although the lack of training and experience was considered a problem by some older day centre users and workers with respect to discipline and general aptitude, their introduction into the service was welcomed by both users and staff, since they offered a unique opportunity for the younger impaired to interact on a regular basis with non-impaired peers.

The data in Chapter Four suggest that the general ethos which evolved within the Contact format was almost solely a consequence of the protracted interactions between users and staff rather than coming from external sources. The aims of the group were to provide both social and, in the non-medical sense, rehabilitative activities within an explicitly voluntarist framework, consonant with the more progressive 'enlightened guardian' model of care. This approach has the advantage of accommodating the needs of the dependent as well as those of the not so dependent within one framework, but because these needs are often contradictory it tends to inhibit user participation and control. This is clearly evident in Chapters Five and Six.

Chapter Five focuses on the users and user relations within the context of the Contact group. Despite the relatively high level of homogeneity among Contact members in terms of age, class, social and economic disadvantage, there were significant disparities in terms of degree of impairment and attitudes regarding dependence, day centre staff and day centre use. I identify four distinct subdivisions or reference groups based on degree of impairment, -observed dependence and friendship groupings. The first includes users who were almost entirely dependent on staff for their social activity, due mainly to the severity of their subjective impairments. The second is probably best understood with reference to the concept 'conformity', since its members appear to have adjusted to their dependent status. They tend to view the day centre and day centre staff in an overtly positive light. Members of the third subdivision are conspicuous by their non-alignment to any of the other factions within Contact. They are floaters and/or loners, and adapt to or 'innovate' in respect of the

circumstances in which they find themselves. The principal characteristic of the fourth and final group in this typology is 'ritualism'. They reject the consequences of their disabled identity and as a result have devalued conceptions of self. This is manifest in their general ambivalence toward day centre attendance. They use the system because they feel they have no choice. These attitudes and frustrations are underpinned by their statements concerning the centres and their covert and occasionally overt animosity toward other users, particularly the conformists.

These differences are explained with reference to differential socialization and association theories, since the conformists were all congenitally impaired and had similar biographies before their day centre use began. I shall argue that they have been socialized into a dependent status by their life experiences prior to day centre attendance. Those in the fourth grouping, on the other hand, were relatively less impaired, had experienced either a separation from the conjugal home or were educated in 'normal' schools for the whole or a large part of their school career, or were adventitously impaired. As a result all were imbued with perceptions of normality, 'able-bodied' normality. These contentions are substantiated with data from the statements of the users themselves and from those of the staff.

An awareness of the different life experiences and attitudes of users is sometimes evident in the practices of staff when they are attempting to 'encourage' user involvement in educational and vocational activities discussed in Chapter Six. Although environmental factors are important in explaining the relatively low level of user involvement in these activities, attention is drawn toward the limitations of policies which advocate structured didactic activity within an unreservedly voluntarist atmosphere such as that in the Contact group, as well as in the day centres generally. In addition, I shall suggest that for over two-thirds of the Contact users the notion of 'rehabilitation' in its literal sense is inappropriate, due primarily to their previous experiences, and that for those with moderate impairments the rehabilitative facilities provided are incompatible with their needs. As a result the majority of users view the centres as a site for social, rather than rehabilitative, activity.

The limited user involvement in formal mechanisms of policy formulation, such as user committees and group meetings, are explained with reference to factionalism and misrepresentation within the Contact group. As a result staff authority remains unchallenged. Formal controls within the day centre system were kept to a minimum, and are generally governed by 'common

sense' usually determined by senior staff in the collective interest of the users, rather than some formal constitution or rule book. Although such a system is open to abuse there was no evidence of any during the study period. Control within the three centres studied was generally considered a non-issue. This is explained by staff with reference to the voluntarist nature of the day centre service and the advancing years of the day centre population as a whole.

The principal area in which control was exercised over Contact users was related to the restrictions on mobility outside the centres. Their statements demonstrate an acute awareness of the external constraints on their movements due to parental influence and the environment. Considerable discretion was exercised by senior Contact staff in this area. In spite of official policy to the contrary they adopted policies which apparently allowed users to leave the buildings at will in the interests of user freedom and independence. However, because some users were more able than others to take advantage of this right, this policy tended to exacerbate the social divisions within the group.

Control within Contact was subject to the normative power relations inherent to the division of labour within the centres. Authority rested in the superordinate status of senior personnel and was dispensed through a subtle combination of 'orchestration' and, when necessary, supervisory control. Discipline was not considered a problem by day centre staff and this is explained by them with reference to users' socialization and their relative independence within the centres, when compared with their dependence in the domestic sphere and the community at large. I note, however, that staff's use of power is limited in the sense that the imposition of punitive sanctions has negative implications for all concerned.

These arguments are further endorsed by the data presented in Chapter Seven which draws attention to the environmental, social and economic barriers to normal integration encountered by users outside the centres (Bowe, 1978). The evidence presented takes the form of observed examples of both individual and group interactions, highlighting the changes in behaviour patterns of the Contact users when outside the centres, and users' statements concerning their experiences and attitudes toward society generally. The importance of the day centres as a nexus of social activity for Contact members is underpinned by reference to their social activities outside the day centres, their general social isolation other than in the domestic sphere and their aspirations and expectations for the future.

In Chapter Eight I report the changes which occurred in the day centres during the eighteen months after the main study was completed. Although the Contact group had ceased to exist in this form the majority of Contact members were still using the system on a regular basis. In addition, there was an expansion of facilities and services specifically for the younger physically impaired, including a large well-equipped day centre located a considerable distance away from the centre of the local community; In view of the fact that the new unit fulfilled a similar role to that of the Contact group, that its extensive facilities will probably discourage users from using those used by the non-impaired, and that its location effectively removes people with disabilities from the local community, I suggest that these developments are likely to make users more dependent on the day centre service rather than less.

In the final analysis this study demonstrates that for many young people with disabilities day services represent an alternative to the debilitating social isolation of the domestic sphere and the harsh realities of life in contemporary Britain. At the same time it also demonstrates how all too frequently the cost to the individual of accepting that alternative results in a dependent status being reinforced. Moreover, given the degree of 'alienation, depression and pessimism' experienced by those excluded from the mainstream of economic and social activity (Willis, 1985) in 'yuptopian' Britain and the limited resources allocated to provision for the young disabled by the present government, it is difficult to see how this situation could be avoided. In Chapter Nine, however, I put forward a number of policy recommendations with regard to day centres which might go some way toward achieving this and conclude that due to the unprecedented demographic changes predicted for Britain in the next two or three decades, involving a rapidly expanding elderly population and the subsequent shortage of labour in the lower age groups, the time for a completely new approach to existing social policies concerned with children and young people with impairments has never been more appropriate or necessary.