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The Ideological Construction of Disability

No attempt to develop a social theory of disability can ignore the issue of ideology for

there is a clear relationship between prevailing social structures, dominant ideology and the way society handles its deviants. (Abbot and Sapsford, 1987, p. 7)

But part of the problematic for social theory is that there is no one universally agreed definition of ideology, and indeed, in some definitions, the very nature of ideology is to obscure the relationship between social structures, social policies and the treatment of deviants.

Here, ideology will be characterised by a set of values or beliefs underpinning social practices, whether those social practices be the work process, medical intervention or the provision of welfare services. But that itself is not enough, for, by leaving it there, social consciousness can be reduced to a pluralist vision of sets of competing ideologies. Hence it is necessary to turn to the work of Gramsci (1971) who attempted to provide a specific link between social structures and ideologies by distinguishing between what he called 'organic' and 'arbitrary' ideologies.

But, further, he attempted to address the issue of power and dominant ideology through the development of the concept of hegemony which becomes more all-bracing than ideology for

It is the sheer taken-for-grantedness of hegemony that yields its full affects - the 'naturalness' of a way

of thinking about social, economic, political and ethical issues. (Hamilton, 1987, p. 8)

The hegemony that defines disability in capitalist society is constituted by the organic ideology of individualism, the arbitrary ideologies of medicalisation underpinning medical intervention and personal tragedy theory underpinning much social policy. Incorporated also are ideologies related to concepts of normality, able-bodiedness and able-mindedness. These ideologies will be the subject of the next two chapters and the issue of hegemony will be returned to subsequently.

INDIVIDUALISM AND IDEOLOGY

The ways in which the rise of capitalism excluded disabled people from the process of work and its consequent social relations was described in the previous chapter. But it also changed the way disabled people were viewed, for 'Capitalism, whether free market or welfare, encourages us to view people ... as a commodity for sale in the labour market.' (Burton, 1983, p. 67)

The requirements of the capitalist economy were for individuals to sell their labour in a free market and this necessitated a break from collectivist notions of work as the product of family and group involvement. It demanded nothing less than the ideological construction of the individual. Or to put it in a slightly different way, 'Thus individualism is seen as being the ideological foundation upon which the transition to capitalism was based.' (Dalley, 1988, p. 32) That this ideological construction of the individual was rooted in history, Marx had no doubt.

The further back we go into history, the more the individual, and, therefore, the producing individual seems to depend on and constitute a part of a larger

whole: at first it is, quite naturally, the family and the clan, which is but an enlarged family; later on, it is the community growing up in its different forms out of the clash and the amalgamation of clans. (Marx, 1913, p. 267)

Hence, individuals always existed but only as part of larger social groupings whether they be families, clans or communities. It was only with the rise of capitalism that the isolated, private individual appeared on the historical stage.

It is but in the eighteenth century, in 'bourgeois society' that the different forms of social union confront the individual as a mere means to his private ends, as an outward necessity. But the period in which this view of the isolated individual becomes prevalent, is the very one in which the inter-relations of society (general from this point of view) have reached the highest state of development. (Marx, 1913, p. 268)

This highest state of development (that is, the rise of capitalism) did not simply bring with it new problems for social order and social control. It also required new ways of seeing or constructing these problems of order and control.

Within this set of problems, the 'body' - the body of individuals and the body of populations appears as the bearer of new variables, not merely between the scarce and the numerous, the submissive and the restive, rich and poor, healthy and sick, strong and weak, but also between the more or less utilizable, more or less amenable to profitable investment, those with greater or lesser prospects of survival,

death and illness, and with more or less capacity for being usefully trained. (Foucault, 1980, p. 172)

This, then, is the ideological underpinning for the separation and specialisation processes which took place with the rise and development of the institution and which were described in the previous chapter.

Further, as Lukes as pointed out, this ideological construction of, or way of seeing, the individual not only legitimates one view but delegitimizes others.

But every way of seeing is also a way of not seeing; and in this case a view of man as essentially property-owning or self-interested or 'rational' or concerned to maximise his utility amounts to the ideological legitimization of a particular view of society and social relations - and the implicit delegitimation of others. (Lukes, 1973, pp. 149-50)

In relating this discussion to disability, it is not the ideological construction of property-owning, self-interested or rational individuals that is important. Rather it is the construction of 'able-bodied' and 'able-minded' individuals which is significant, with their physical capabilities of operating the new machines and their willingness to submit to the new work disciplines imposed by the factory.

This particular ideological construction can best be understood within Gramsci's distinction between 'organic' and 'arbitrary' ideologies.

One must distinguish between historically organic ideologies, those, that is, which are necessary to a given structure, and ideologies that are arbitrary, rationalistic, or 'willed'. To the extent that ideologies are historically necessary they have a validity which

is 'psychological'; they 'organise' human masses, and create the terrain on which men move, acquire consciousness of their position, struggle, etc. To the extent that they are arbitrary they only create individual 'movements', polemics and so on.
(Gramsci, 1971, p. 377)

These organic and arbitrary ideologies, would better be called 'core' and 'peripheral', precisely because they are interrelated and interdependent; in this particular case the core (organic) ideology of individualism gives rise to the ideological construction of the disabled individual as the antithesis of able-bodiedness and able-mindedness, and the medicalisation of disability as a particular kind of problem. Precisely how this construction occurred now needs to be discussed.

THE INDIVIDUALISATION AND MEDICALISATION OF DISABILITY

How disability came to be conceived within the core ideology of individualism as an individual problem, can be understood by reference to the work of Foucault in general and his work on madness in particular (Foucault, 1965). His views have been summarised as follows:

The very idea that 'madness' is individual pathology, a negative phenomenon, a defect to be remedied, is the object of his investigation. This concept of madness is not the achievement of psychiatric rationality. Rather it is a complex and non-intentional social product, which formed the basis for psychiatry.
(Hirst and Woolley, 1982, p. 165)

Thus, for Foucault, psychiatry as organised professional activity only becomes possible when (i) madness has been transformed from a diverse set of social valuations to

a uniform category of pathology, and (ii) the mad have been excluded from normal social life and isolated in a specialist domain. Central to the argument is that there can be no such thing as madness without the idea of 'unmadness'; reason without unreason, to be less clumsy.

If we pursue this in relation to disability, then perhaps things will become clearer. The idea of disability as individual pathology only becomes possible when we have an idea of individual able-bodiedness, which is itself related to the rise of capitalism and the development of wage labour. Prior to this, the individual's contribution had been to the family, the community, the band, in terms of labour, and while, of course differences in individual contributions were noted, and often sanctions applied, individuals did not, in the main, suffer exclusion. Under capitalism that is precisely what happened and disability became individual pathology; disabled people could not meet the demands of individual wage labour and so became controlled through exclusion.

This process of exclusion was facilitated by focusing on the body, of individuals and populations, and with the rise of capitalism, the main group who came to focus their gaze on the body, was the medical profession. As disabled people were part of the process of control by exclusion, the medicalising of disability was connected to the rise of the medical profession and the development of 'the germ theory of illness and disease'.

A classic illustration of the medical model is the germ theory, derived from the scientific medical work of Pasteur and Koch in the nineteenth century; their work established a scientific basis for the emergence of medicine as a profession equipped with a satisfactory knowledge basis. The medical model is not concerned primarily with questions of prevention

since it approaches the problem of disease through the experience of germ theory which involves a highly interventionist and specific form of medical practice. Germ theory was simply one component within a wider scientific revolution in Victorian medicine. (Turner, 1987, p. 214)

This approach, based upon the medical model, ignores the experience of illness and disease and neglects issues of prevention. In addition many of the major disorders in modern society have no known biochemical cause or are unresponsive to medical treatments. Finally, this approach ignores the influence that cultural, or even sub-cultural factors, may have upon the disease process. Despite these well-known criticisms, it remains true that in the twentieth century, we have seen an increasing medicalisation of society; medicine has acquired the right to define and treat a whole range of conditions and problems that previously would have been regarded as moral or social in origin (Conrad and Schneider, 1980; Manning and Oliver, 1985).

That disability has become medicalised, there can be no doubt. Doctors are centrally involved in the lives of disabled people from the determination of whether a foetus is handicapped or not through to the deaths of old people from a variety of disabling conditions. Some of these involvements are, of course, entirely appropriate, as in the diagnosis of impairment, the stabilisation of medical condition after trauma, the treatment of illness occurring independent of disability and the provision of physical rehabilitation. But doctors are also involved in assessing driving ability, prescribing wheelchairs, determining the allocation of financial benefits, selecting educational provision and measuring work capabilities and potential; in none of these cases is it immediately obvious that medical

training and qualifications make doctors the most appropriate persons to be so involved. Not only that, but many of the newer professions such as physiotherapy, occupational therapy, health visiting, nursing and even teaching, either work in organisations hierarchically dominated by doctors or have their professional practice structured by a discourse based upon the medical model.

There have, of course been substantial gains from this medicalisation of disability, which has increased survival rates and prolonged life expectancies for many disabled people as well as eradicating some disabling conditions. But the issue for the late twentieth century is not one of life-expectancy but expectation of life and it is here that the negative and partial view prompted by medicalisation is most open to criticism.

The medical model of disability is one rooted in an undue emphasis on clinical diagnosis, the very nature of which is destined to lead to a partial and inhibiting view of the disabled individual.

In order to understand disability as an experience, as a lived thing, we need much more than the medical 'facts', however necessary these are in determining medication. The problem comes when they determine not only the form of treatment (if treatment is appropriate), but also the form of life for the person who happens to be disabled. (Brisenden, 1986, p. 173)

The medicalisation of everyday life and of society is thus a fact for the vast majority of the current population, disabled people among them. How this general phenomenon came about now needs to be considered along with specific explanations of how the process occurred in respect of disability. To facilitate this, the

historical framework developed by Abrams (1982) and discussed in the previous chapter, will be returned to, incorporating enlightenment, necessity, action and power theories of welfare.

THEORIES OF MEDICALISATION

The enlightenment theory of medicalisation suggests that medicalisation is a consequence of both the rise of science and the progress of humanitarian ideas. Within this explanation, medicalisation is seen as largely beneficial and progressive, providing treatment to the ill rather than physical punishment for sinners, or deprivation of liberty for the criminal. While this may appear to be progressive, treatment may not always be experienced in this light and the consequences of medical labels may be negative and profound. This point has been made with regard to epilepsy:

In the initial decades of this century much was learned about epilepsy. As a result physicians gained much better control of the epileptic process (which sometimes results in seizures). The desire to control the disease, however, seems to go hand in hand with the desire to control the diseased person. Thus, epileptics were both helped and harmed; they were benefitted insofar as their illness was more accurately diagnosed and better treated; they were injured insofar as they, as persons, were stigmatised and socially segregated ... It has taken decades of work, much of it still unfinished, to undo some of the oppressive social effects of 'medical progress' in epilepsy, and to restore the epileptic to the social status he enjoyed before his disease became so well understood. Paradoxically then, what is good for epilepsy may not be good for the epileptic. (Szasz, 1966, p. 3)

This leads on to the necessity theory of medicalisation, which stresses the need to impose order in the new industrial society and describes the way in which medicine became the main agent in this process of social control (Zola, 1972). This explanation contains two strands; one seeing medicine as an independent social and ideological force and the other seeing medicine as an agent of the capitalist ruling class and a contributor to the 'legitimation of capitalism' (Navarro, 1976). Allying medicalisation and social control has its drawbacks, for it has the potential to produce a system of social control 'unlimited in its potential applications' (Kittrie, 1971, p. 362); and a profession and society

which are so concerned with physical and functional well being as to sacrifice civil liberty and moral integrity must inevitably press for a scientific environment similar to that provided for laying hens on progressive chicken farms - hens who produce eggs industriously and have no disease or other cares. (Freidson, 1970, p. 356)

The action theory of medicalisation sees this process as the struggle between various groups to impose their own specific set of meanings upon particular social phenomena. Within this framework, the question of why medical labels stick to some groups or conditions and not others is always an empirical question. Hence campaigns to medicalise some conditions such as alcoholism and hyperkinesis and to demedicalise others such as homosexuality are always consequent upon the struggle between competing groups. The fact that throughout the twentieth century, far more social phenomena have been medicalised than demedicalised is explained by reference to the notion of 'medical imperialism', the medical profession winning battles both to define and treat these phenomena.

What it does not explain is the success of the medical profession in achieving this dominant position. This requires a further dimension, supplied by the power theory of medicalisation. There are at least three versions of this; the first suggests that this dominance has been achieved because of the superiority of medical knowledge (based on science) over other forms of knowledge; the second suggests that power was achieved because the medical profession was well-organised and able to gain dominant positions within the new bureaucracies arising as part of the rationalising of society; the third emphasises the interconnections between the medical profession and the capitalist ruling class.

These explanations, taken separately, offer only a partial account of the medicalisation process for it was certainly shaped by the development of scientific and medical knowledge, by the need for more effective and far-reaching forms of social control, by the struggles between competing groups and by the structure and location of power. What is needed is an explanation which incorporates all these elements; which reconceptualises medical intervention as social control, medical knowledge as ideology and which links the two. But before attempting to provide this kind of explanation, it needs to be noted that few writers have attempted to explain this issue of the medicalisation of disability.

While there is an ever-burgeoning literature on the medicalisation of social problems generally, there have been few attempts to discuss the medicalisation of disability, either in historical or current context. Where disability is discussed, its location within the medical model goes unchallenged and explanations for medically-dominated service provision rarely go beyond the

enlightenment theory of welfare. There are two exceptions to this, however, which need to be discussed.

The first of these is contained in the work of Stone (1985) who casts doctors in the role of 'reluctant imperialists'. Her central thesis is that the disability category performs the function of sorting people into the work-based or needs-based systems, and consequently, some allocation method needed to be developed in order to carry out this task. This was done by making disability a clinical concept and hence, assigning the role of allocation to the medical profession. However,

disability certification was not a task the profession wanted to assume. Most physicians believed that medical science was not capable of assessing disability, and that adoption of the certifying role would only create enormous tensions between doctors and their patients. (Stone, 1985, p. 112)

However, once it became obvious that medical certification was going to be the mechanism of allocation, the profession took the role on, fearing that if they did not, a government-created corps of physicians might grow up to rival their own independent profession.

While it may be true that certain key members of the American Medical Association took this view at one time specifically in respect of disability, the medical profession as a whole has not been reluctantly imperialist in industrial societies, notably with regard to other areas such as madness. Hence the medicalisation of disability was as much a product of the structural position of the medical profession in capitalist society as it was the attitudes and beliefs of particular groups of doctors.

Just such a structural explanation has been provided by Finkelstein (1980) who links medicalisation with the rise of the institution and the segregation of disabled people and who argues that this segregation facilitated the development of a whole range of specialist, professional workers.

Thus the hospital environment facilitated the development of nurses, physiotherapists, occupational therapists, social workers (almoners), counsellors, etc., and the alms houses, asylums, charitable homes ensured the success of the move towards segregation. THE DEVELOPMENT OF SUCCESSFUL MEDICAL PRACTICES IN HOSPITALS ENSURED GREATER NUMBERS OF PEOPLE WITH PHYSICAL IMPAIRMENTS SURVIVING AND MUST HAVE STRENGTHENED THE CONNECTION BETWEEN DISABLED PEOPLE AND INSTITUTIONS AS WELL AS FACILITATING THE MEDICAL DOMINANCE IN THE FIELD. (My emphasis; Finkelstein, 1980, p. 10)

But seeing medicalisation (medical dominance in Finkelstein's terms) arising from the establishment and success of hospital-based medicine is only part of the story, for this hospital-based medicine itself arose out of the need to classify and control the population and to distinguish between workers and non-workers within the new capitalist social order. Hence the medicalisation of disability occurred historically as part of this wider social process, and the strategic position that the medical profession was able to achieve for itself under capitalism.

Part of the reason for this medicalisation generally was the success of the germ-theory approach to treating certain conditions, but the twentieth century has seen some

fundamental changes in the patterns of disease and disability.

Changing patterns of disease and societal response to these new problems has aggravated the medical care crisis and underlined the growing importance of the disability problem. The health problems apparent today have few quick and inexpensive solutions.
(Albrecht and Levy, 1984, p. 49)

Medical interventions based upon germ theory are no longer successful with the chronic and degenerative diseases which are coming to dominate morbidity rates in modern, industrial societies. There are no cures, and maintenance rather than treatment has come to play a major part in medical intervention.

This raises the question as to why, given this changing pattern and the fact that many disabling conditions no longer respond to medical treatments (i.e. the cure), does the medical profession continue to dominate the sphere of disability? A major factor, undoubtedly, is that the medical profession has expanded the area of its activity, to rehabilitation as well as treatment, as the pattern of diseases shifted from acute to chronic.

As demand for rehabilitation services increased and insurance benefits expanded, there was an incentive for physicians to enter the rehabilitative field. Under the aegis of designing comprehensive medical rehabilitation programs, hospitals, and physicians began to incorporate rehabilitation services into the medical model. Definitions of disabling conditions and appropriate treatments were expanded to include medical intervention and physician control. (Albrecht and Levy, 1981, p. 22)

The power of the medical profession and its strategic structural position cannot mask the defects in the medicalisation of rehabilitation any more than they can mask the defects in the medicalisation of treatment.

These defects are well-known: the physicalist nature of its programmes to the neglect of other personal and social factors (Oliver et al., 1988); the difficulties in measuring success or failure and hence the concentration on employment status as a measure of success (Albrecht and Levy, 1984); and the failure to involve disabled people meaningfully in the whole rehabilitation process (Finkelstein, 1988). Even the economic rationality underpinning the rehabilitation industry is being called into question; originally developed to turn (or return) people into productive and socially useful human beings, their cost-effectiveness is increasingly being called into question:

Disability programs are considered to be very expensive and rapidly becoming more so, and there is concern whether resources are being efficiently allocated. (Erlanger and Roth, 1985, p. 319)

CORE AND PERIPHERAL IDEOLOGIES

Despite these criticisms and questions, the medical and rehabilitation enterprises remain two of the most important of the human service industries and this is closely connected with the way both practices are linked to social control and their theories fit with the ideology of capitalism and the construction of the able-bodied individual. Thus, for example,

The aim of returning the individual to normality is the central foundation stone upon which the whole rehabilitation machine is constructed. If, as happened

to me following my spinal injury, the disability cannot be cured, normative assumptions are not abandoned. On the contrary, they are re-formulated so that they not only dominate the treatment phase searching for a cure but also totally colour the helper's perception of the rest of that person's life. The rehabilitation aim now becomes to assist the individual to be as 'normal as possible'.

The result, for me, was endless soul-destroying hours at Stoke Mandeville Hospital trying to approximate to able-bodied standards by 'walking' with calipers and crutches ... Rehabilitation philosophy emphasises physical normality and, with this, the attainment of skills that allow the individual to approximate as closely as possible to able-bodied behaviour (e.g. only using a wheelchair as a last resort, rather than seeing it as a disabled peoples' mobility aid like a pair of shoes is an able-bodied person's mobility aid). (Finkelstein, 1988, pp. 4-5)

This ideology of able-bodied normality underpins the professional approach to the issue of disability from pre-birth until death. Thus, the Abortion Act (1967) makes termination possible if 'there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped'. No strict criteria are laid down to specify abnormality, nor is a definition of seriously handicapped provided, so the termination decision is left in the hands of two doctors. Given the earlier discussion of the difficulties of defining disability and handicap, this decision will ultimately be based upon personal judgements of individuals, who, whatever their training, are not immune from the fetters of the ideology of the able-bodied and able-minded individual.

It should be made clear that this is not an attempt to engage in the 'abortion debate' but to illustrate the similarities in the ideologies of professional practice in otherwise disparate areas. This ideology underpinning abortion has implications for disabled people:

The general consensus is that if a disabled person admits that eugenic abortion is justifiable, he is thereby undermining the value of his own life.
(Graham Monteith, 1987, p. 38)

and for society:

if able-bodied society were to accept that those with disabilities are equal human beings with rights, they would also have to abandon the notion that screening and abortion are benefits to society, and that the earlier a handicapped person is killed off the better for all concerned. (Davis, 1987, p. 287)

This ideology is not only relevant to life-and-death issues but to other areas as well. The current popularity of 'conductive education' is a product of this ideology of the able-bodied individual, for its aim is to teach children with cerebral palsy to walk, talk and engage in all other activities in as near normal a way as possible. No consideration is given to the issue of the ideology of 'normality' nor to the idea that the environment could be changed rather than the individual.

The object of Conductive Education is not to accommodate the severe dysfunctional patients in an institute, or to send them to a special school, but to accomplish a basic task to render possible a normal education, travelling in the streets, self-supporting and work. In order to bring about an equilibrium between child and environment, we do not change

the environment, but the adaptation of the child's constitution. (Hari, 1968, quoted in Cottam and Sutton, 1985, pp. 41-2)

And scant regard is paid to the costs involved in terms of pain, coercion, loss of childhood, disruption of family life, acceptance of alternative ways of doing things, and so on. Again this is not a consideration of the pros and cons of conductive education but a pointer to the ideological similarities that it has with other practices.

The search for the cure of a variety of disabling conditions such as multiple sclerosis, muscular dystrophy and spinal injury is also supported by this ideology as is much of the practice of geriatric medicine aimed at restoring the functional capacities of old people rather than providing the support of services which allow them to live in dignity with their declining physical capabilities. Long ago, the unitary idea of able-bodied and able-mindedness was mocked:

in an important sense there is only one complete unblushing male in America: a young, married, white, heterosexual Protestant father of college education, fully employed, of good complexion, weight and height, and a recent record in sports ... The general identity values of a society may be fully entrenched nowhere, and yet they can cast some kind of shadow on the encounters encountered everywhere in daily living. (Goffman, 1963, pp. 128-9)

But these identity values can be structurally located and are fully entrenched in the core ideology of individualism and they cast a shadow on the lives of disabled people through their incorporation into the peripheral ideologies of able-bodiedness and able-mindedness and the medicalisation of disability.

Shadows are cast on the lives of disabled people not simply because of the existence of these ideologies but because of the discursive practices (Foucault, 1972) which accompany them. Hence, if we return to the issue of the cure for disabling conditions, the discursive practices surrounding this issue usually focus on walking. Ignoring the strictures of Finkelstein (1988) on walking, Dr Hari suggests

The duty of the pedagogue is to promote the discovery of conditions which enable the spinal cord injury patient to learn how to walk, etc. and enter everyday life without any special mechanism.

But further, 'In order to make a spinal cord injury patient walk, teaching must restore the will of the individual to do so. (Hari, 1975, quoted in Cottam and Sutton, 1985, pp. 161-2) Thus the implication is clear: those who remain unable to walk, lack the will so to do.

Similarly, in respect of ageing, much medical intervention is geared towards returning the old person to as near normality as possible. Usually the spoken assumptions behind this normality are the functional capacities and capabilities of twenty-five-year-olds and it is these to which the old person must aspire. Further

The bio-medical theories not only individualise and medicalise old age, but also they overlook the relationship between socio-economic status, the economy and health. (Estes et al., 1982, p. 153)

This has further consequences in that it is becoming increasingly less possible

to debate the broad span of social and allied policies necessary to change the attitudes which exist in this political and cultural climate which identifies older people as patients and social casualties. (Midwinter, 1987, p. 1234)

Shapiro (1981) uses this idea to discuss stuttering as disability and suggests that these discursive practices direct our attention to the stutterer's mouth as the source of the problem of stuttering. He goes on to suggest there are, however, other choices on which we could focus our attention.

In the case of the stuttering child, for example, one might well ignore the mouth and deal with the parent-child relationship, for the parents might be putting pressure on the child that, if removed, might bring an end to stuttering. Or, going further out in the causal sequence, the parents might be under pressure, given such situations as a stressful work setting or a stressful marital relationship. (Shapiro, 1981, pp. 92-3)

He goes on to suggest that we could move further and further away from the stutterer's mouth until we focused on the 'structure of the economy as a whole'.

But his analysis itself remains locked into a discursive practice which sees stuttering as stress-related. An alternative might be to see stuttering as merely a natural phenomenon and one of the myriad ways in which communication takes place, which might also include Oxbridge English, Esperanto, sign language, Braille, Makaton and so on. Thus the problem of stuttering can therefore be seen as the result of social expectations about appropriate (and inappropriate) ways of

communicating rather than the product of stress among individuals or families.

Shapiro, of course, recognises that these discursive practices are not free-floating but grounded in particular concrete practices and forms of social relations. And

The way that we speak about phenomena like stuttering is conditioned by the discourses within which such phenomena are embedded. Speech pathology, for example, is not a phenomenon lying around waiting to be discovered. It is an ideological commitment that represents various modes of responsibility and control. The fact that 'speech problems' are regarded as such is thus the function of a latent ideology, one that is structurally represented by the vocations of persons such as speech therapists. We therefore look into the mouths of stutterers because we regard it as relatively more legitimate to load the responsibility for stuttering onto the stutterer than elsewhere. (Shapiro, 1981, p. 93)

Hence disability is structurally represented by the vocations of doctors and the para-medical professions, and we load responsibility for the restrictions that disabled people experience on to disabled people themselves, who are restricted because of the functional or psychological limitations imposed by their individual impairments; rather than by the social restrictions imposed by society.

To sum up, the disabled individual is an ideological construction related to the core ideology of individualism and the peripheral ideologies related to medicalisation and normality. And the individual experience of disability is structured by the discursive practices which stem from these ideologies.

Lukes, in his discussion of individualism in general, comes to conclusions of relevance to the ideological construction of the disabled individual. He recognises that there have been indispensable gains from the rise of individualism; it was central to the breaking down of traditional hierarchies and privileges and in establishing the legal rights of individuals. Further, he suggests that

These are crucial and indispensable gains but, if we are to take equality and liberty seriously, they must be transcended. AND THAT CAN ONLY BE ACHIEVED ON THE BASIS OF A VIEW OF UN-ABSTRACTED INDIVIDUALS IN THEIR CONCRETE, SOCIAL SPECIFICITY, WHO IN VIRTUE OF BEING PERSONS, ALL REQUIRE TO BE TREATED AND TO LIVE IN A SOCIAL ORDER WHICH TREATS THEM AS POSSESSING DIGNITY, AS CAPABLE OF EXERCISING AND INCREASING THEIR AUTONOMY, OF ENGAGING IN VALUED ACTIVITIES WITHIN A PRIVATE SPACE, AND OF DEVELOPING THEIR SEVERAL POTENTIALITIES. (My emphasis; Lukes, 1973, p. 153)

Likewise, this is not to deny the real and indispensable gains brought about by the individualisation and medicalisation of disability, but these gains must also be transcended and the italicised portion of the above quotation would not be out of place in any charter on disability. Before considering the implications of this view of un-abstracted individuals for disability policy, it is necessary to consider the disabled individual who is located within this ideological construction, and that will be discussed in the following chapter.