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Disability: A Choice of Models

For most of the twentieth century in 'Western' societies, disability has been equated with 'flawed' minds and bodies. It spans people who are 'crippled', 'confined' to wheelchairs, 'victims' of conditions such as cerebral palsy, or 'suffering' from deafness, blindness, 'mental illness' or 'mental handicap'. The individual's impairment or 'abnormality' necessitates dependence on family, friends and welfare services, with many segregated in specialized institutions. In short, disability amounts to a 'personal tragedy' and a social problem or 'burden' for the rest of society.

However, from the late 1960s, this orthodoxy in thinking and practice became the target of campaigns across Europe and North America. Disabled people, particularly those forced to live in residential institutions, took the lead in calling for policy changes. Their demands highlighted the importance of much greater support for 'independent living' in the community (Hunt 1966a; Brattgard 1974), and in the United States also assumed a civil rights focus (DeJong 1979). Disabled activists and organizations of disabled people were united in condemning their status as 'second-class citizens' (Eisenberg et al. 1982). They redirected attention to the impact of social and environmental barriers, such as inaccessible buildings and transport, discriminatory attitudes and negative cultural stereotypes, in 'disabling' people with impairments (UPIAS 1976; Bowe 1978).

By contrast, the academic literature broadly accepted the 'orthodox' view that disability is an individual and medical issue. Although gender and 'race' were by the 1980s generally recognized as distinctive causes of social oppression, this was not true of disability. Disabled critics dismissed prevailing accounts in the social sciences as irrelevant, 'theoretically backward' (Abberley 1987: 5) and resolutely 'disablist' (Oliver 1996b). 'There were no disjunctures between the dominant cultural narrative of disability and the academic narrative. They supported and defended each other' (Linton 1998: 1).

In this introductory chapter, we begin by outlining social science approaches through the 1960s and 1970s that analysed disability as a form of social deviance and sickness. Next, we trace the gathering critique by disabled activists and academics and the development of an alternative, socio-political approach to disability. Finally, we identify key issues in disability theory and practice for more detailed discussion in later chapters.

Disability as a personal tragedy

Twentieth-century social theory typically followed medical judgements in identifying disabled people as those individuals with physical, sensory and cognitive impairments as 'less-than-whole' (Dartington et al. 1981: 126), and hence unable to fulfil valued social roles and obligations. This incapacity left them 'dependent on the productive able-bodied' (Safilios-Rothschild 1970: 12). These and other negative associations meant that disability was perceived as a 'personal tragedy' (Oliver 1983). This encompasses an individual and largely medicalized approach: first, disability is regarded as a problem at the individual (body-mind) level; second, it is equated with individual functional limitations or other 'defects'; and third, medical knowledge and practice determines treatment options. From a societal perspective, disability is dysfunctional:

> the values which underpin society must be those which support the interests and activities of the majority, hence the emphasis on vigorous independence and competitive achievement, particularly in the occupational sphere, with the unfortunate spin-off that it encourages a stigmatising and negative view of the disabilities which handicap individuals in these valued aspects of life (Topliss 1982: 112).

For most of the twentieth century, this personal tragedy approach was applied in a variety of educational and charitable institutions and through medical and psychological interventions. Indeed, large numbers of disabled people were 'put away' in segregated institutions on the grounds that it was for their own good and to stop them being a burden on others (Goffman 1961). Yet, in practice, institutional regimes were often harsh, and long-term residents were liable to be 'written off' as 'socially dead' while awaiting the ends of their lives (Miller and Gwynne 1972).

Disability and social deviance

The problematic aspects of disability from a societal viewpoint are vividly illustrated in functionalist analyses of health and sickness. As outlined by Talcott Parsons (1951), sickness is akin to social deviance, because it poses a threat to 'normal' role performance and wider economic productivity and efficiency. This leads to the establishment of a sick role that grants temporary and conditional legitimacy to the sick person. It seeks to achieve a balance between acknowledging 'incapacity' and preventing 'motivated deviance' or malingering. Society accepts that the sick person cannot get better simply by an 'act of will' and he or she is permitted to withdraw temporarily from 'normal' social roles. In return, the individual must obtain medical confirmation of their condition and follow the recommended treatment, while agreeing the importance of leaving the sick role behind as soon as possible.

However, the applicability of the sick role to those with a 'chronic illness and disability' attracted widespread criticism, because these conditions are defined as long-term if not irreversible. One response was to construct a separate 'disabled role' (Safilios-Rothschild 1970) characterized by adjustment to an extended but authorized dependency (Haber and Smith

1971). The individual is required to co-operate with rehabilitation professionals in order to achieve some degree of 'normality'. This describes a hierarchical relationship where the professional (helper) identifies the needs and capabilities of the lay (helped) person and prescribes appropriate individualized 'solutions' ranging from health and social care to special educational provision (Finkelstein 1983). Moreover, it adopts the profession's view of the 'ideal' patient as someone who defers to its knowledge and authority, and ignores the potential for contrary lay interests or expertise (Freidson 1970).

From a contrary theoretical perspective, symbolic interactionists stressed the social construction of what is perceived as deviance in everyday interaction:

> *social groups create deviance by making the rules whose infraction constitutes deviance*, and by applying those rules to particular people and labelling them as outsiders. From this point of view, deviance is *not* a quality of the act the 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. (Becker 1963: 8; – emphasis original)

A significant benchmark for studies of social reactions to difference was Charles Lemert's (1951) distinction between *primary* and *secondary* deviance. Primary deviance arises where social norms or rules are broken but there are no long-lasting consequences. In contrast, secondary deviance generates a more significant and enduring social reaction that is sufficient to produce a deviant identity and status. Generally, the attribution of deviance to people with impairments is associated with 'ascribed' (involuntary) rather than 'achieved' (purposive) rule breaking. Nevertheless, particular groups, including black people and women, disproportionately attract specific psychiatric labels such as 'schizophrenia' and 'depression' respectively (Scheff 1966; Busfield 1986). Once applied, a medical label such as 'mental illness' at least confirms and at most transforms the public perception of an individual. It is also difficult to challenge or remove a medical label (Freidson 1965, 1970).

As a further illustration of the social construction of deviance, the 'recipients' of deviant labels must be taught how to act out their ascribed role. Professionals and specialized organizations are central to this socializing process. Robert Scott, in *The Making of Blind Men* (1969), illustrates how agencies responsible for the education and training of people labelled as blind reorganize the personal identity of their clients so as to conform to the professionals' image of a 'blind person', even though 'there is nothing inherent in the condition of blindness that requires a person to be docile, dependent, melancholy, or helpless; nor is there anything about it that should lead him to be independent or assertive' (Scott 1969: 14). New entrants are rewarded for conforming to staff expectations. They are praised for being 'insightful' when they do what the rehabilitation team wants, and are criticized for 'blocking' or 'resisting' when they disregard agency aims. This regime generally brings about a profound change from recruitment to completion of training. Nevertheless, as Scott demonstrates with case studies of Sweden, England and America, there are significant national differences in the roles and expectations of blind people.

The preoccupation among service providers with appropriate adjustment on the part of those with an impairment is again vividly illustrated in the application of psychological 'loss' or bereavement models. One of the most widely cited studies contains a four-stage process of psychological adjustment and rehabilitation to a severe spinal cord injury (Weller and Miller 1977). The initial reaction of 'shock' and horror is followed by 'denial' or despair that any recovery is possible, leading to 'anger' at others, and finally to 'depression' as a necessary preliminary to coming to terms with diminished circumstances. This 'acceptance' or 'adjustment' may not be reached until one or two years later. A parallel response trajectory has been identified for children with impairments attending a residential school (Minde 1972). Its key phases are 'disorientation' (following the loss of links with home and the local community), 'depression' (as the permanency of their impairment is confirmed by older pupils), 'anger' (at their difference from non-disabled peers), and finally, 'acceptance' (of the limitations of the disabled role).

The determinism of these 'adjustment to loss' models effectively sets aside the subjective experiences of disabled people and the specific socio-cultural and economic context (Albrecht 1976). While there is widespread agreement that there are often significant psychological (and other) costs associated with impairment, such models impose a 'psychological imagination' based on able-bodied assumptions of what it is like to live with an impairment (Oliver 1983).

Stigma: managing a spoiled identity

An associated feature of interactionist studies is their emphasis on individual coping or management strategies. Erving Goffman (1963) provides the classic study of responses to stigma, or a 'spoiled identity', including 'abominations of the body', with illustrations of those described as 'blind', 'deaf', 'crippled', 'deformed', 'disfigured', 'mentally ill' and 'stutterers'. He acknowledges that there is no necessary association between such attributes and their contemporary stereotype, but explores how the meaning of these marks of difference is negotiated through social interaction. In mid-twentieth-century America, he lists the benchmark 'identity norms' for a male as being 'a young, married, white, urban, northern heterosexual Protestant father of college education, fully employed, of good complexion, weight, and height, and a recent record in sports' (Goffman 1963: 128).

His characterization of 'abnormals' resonates with other social psychological writings on 'difference'. These highlight the 'liminality' of those on the margins of what society regards as 'normal':

> The long-term physically impaired are neither sick nor well, neither dead nor alive, neither out of society nor wholly in it. They are human beings but their bodies are warped or malfunctioning, leaving their full humanity in doubt. . . . They are neither fish nor fowl; they exist in partial isolation from society as undefined, ambiguous people. (Murphy 1987: 112)

Goffman's interest in 'undesired differentness' (1963: 5) centres on how individuals manage their 'spoiled identity' in everyday social interaction – what one sociological text refers to as the 'inevitable problems of living that confront the disabled as a result of their impairments' (Clinard and Meier 1989: 368). Encounters between 'normals' and 'stigmatized' people are characterized by immediate and often acute tensions for the visibly 'discredited', while for the 'discreditable' whose stigma is not immediately apparent the dilemma is whether or not to display their 'abnormality'. He documents a broad range of 'passing' (hiding the stigma) and 'covering' (reducing its significance) strategies to avoid embarrassment and social sanctions. These include repeated and often painful medical and surgical procedures to make the individual 'more normal' or less likely to attract a critical public gaze. The only other option for the stigmatized person is 'withdrawal' from social interaction.

Fred Davis, in a study of the social interaction between non-disabled people and those with a visible impairment, lists some of the points of tension: 'the guarded references, the common everyday words suddenly made taboo, the fixed stare elsewhere, the artificial levity, the compulsive loquaciousness, the awkward solemnity' (Davis 1961: 123). Nevertheless, he outlines a process of 'deviance disavowal' whereby the difficulties in social interaction are gradually 'normalized' over time. He identifies three main stages, starting with 'fictional acceptance', where interaction is kept to a minimum. A second 'breaking through' period begins when the stigmatized person encourages the 'normal' person to disregard their condition. The end-point is a 'normalized relationship' where difference is dissipated, leading to the seal of approval from a non-disabled person – 'I don't think of you as disabled' – so unthinkingly confirming the latter's tragic fate. The 'well-adjusted' disabled person is someone who lives up to non-disabled peoples' expectations as brave, cheerful and grateful when being helped. Conversely, they are quickly criticized if they act 'out of character' by being assertive and demanding.

The stigma label is further characterized by its potential to 'spread'. At the individual level, physical impairment is sometimes taken as an indication of a generalized incapacity – as typified by the 'Does he or she take sugar?' syndrome. In addition, negative attitudes and behaviour may be extended to other family members as a 'courtesy stigma' (Goffman 1963).

A general feature of this interactionist literature is its concentration on the defensive manoeuvrings of disabled people. This suggests that 'those stigmatised are apparently firmly wedded to the same identity norms as normals, the very norms that disqualify them' (Gussow and Tracey 1968: 317). However, there are exceptions: the treatment of disabled people is not always represented as benevolent, and not all disabled people take over the values of non-disabled people. In his study of life in a psychiatric institution, Goffman (1961) acknowledges that asylum inmates are 'colonized' and their supposed 'helpers' also act as jailers. He also outlines a continuum of potential responses to incarceration: from 'true believers' to 'resistors'. None the less, these examples are submerged beneath a general emphasis on achieving social acceptance and accommodating to the demands of 'normals'.

Deviance and social control

From a conflict perspective, studies of the social construction of disability took their cue from C. Wright Mills (1963), who argued that the definition of social problems must be located within wider material and political contexts, including the power relations and conflicts between dominant and subordinate classes. Historically, there was a trend away from judgements of social deviance rooted in religious criteria of 'badness' towards medical judgements of 'sickness'. The medicalization of disability confirmed the arrival of an orthodox medical profession, with State-legitimated authority in the delivery of health and illness services (Conrad and Schneider 1980). Over time, there has been a proliferation of other 'moral entrepreneurs' (Becker 1963), in education, psychology, counselling and social work, all seeking an enhanced role in services for people with accredited impairments.

The growing impact of professionals in general and medicine in particular on the lives of disabled people proceeded unevenly. It is most evident in studies of mental illness that include a full-blown critique of a self-serving profession (psychiatry) for exploiting its power of labelling and collaborating in a wider process of social control. From an 'anti-psychiatry' perspective, the concept of mental illness is

dismissed as a 'myth', or at least a socio-political construct, but there was little discussion of alternative support paths (Szasz 1971; Ingleby 1981). By comparison, the medicalization of physical and sensory impairments attracted little if any criticism, but rather confirmed the existence of a 'caring society'.

Challenging the disabling society

It was largely left to disabled people to develop their own critique of the conventional approaches to disability. A key contribution in Britain was Paul Hunt's edited collection entitled *Stigma: The Experience of Disability* (1966b). This challenged the standard preoccupation with the medical and personal 'suffering' experienced by individuals with an impairment. In his own essay, Hunt argued that 'the problem of disability lies not only in the impairment of function and its effects on us individually, but also, more importantly, in the area of our relationship with "normal" people' (Hunt 1966a: 146) A sharp dividing line is drawn between the social lives and interests of 'able-bodied' and disabled people. The latter are 'set apart from the ordinary' because they pose a direct 'challenge' to commonly held societal values: 'as unfortunate, useless, different, oppressed and sick' (p. 146).

Disabled people are viewed as 'unfortunate' because they are unable to enjoy the social and material benefits of contemporary society. These include the opportunity for marriage, parenthood and everyday social interaction. The few exceptions are lauded for their 'exceptional courage', but this simply confirms the 'tragic' plight of the vast majority. Indeed, it is overwhelmingly non-disabled people who like to celebrate such 'triumph over tragedy' heroics (Dartington et al. 1981).

The perception of disabled people as 'useless' flows from their lack of engagement in mainstream economic activities. As a consequence of their failure to conform to 'normality', whether in appearance or in control over their minds and bodies, they are set apart as 'different'. Moreover, 'People's shocked reactions to the "obvious deviant" stimulate their

own deepest fears and difficulties, their failure to accept themselves as they really are and the other person simply as "other"' (Hunt 1966a: 152).

The level and form of prejudice against disabled people amounts to being 'oppressed'. It is illustrated by the discrimination widely practised in the built environment, employment, leisure and personal relationships. Finally, disabled people clash with 'able-bodied' values in so far as they are defined as 'sick, suffering, diseased, in pain' (Hunt 1966a: 155). This represents everything that the 'normal world' most fears – 'tragedy, loss, dark, and the unknown' (p. 155). 'Being seen as the object of medical treatment evokes the image of many ascribed traits, such as weakness, helplessness, dependency, regressiveness, abnormality of appearance and depreciation of every mode of physical and mental functioning' (Zola 1993: 168).

What also now emerges is a contrast between the individual model's 'property' approach that equates disability with an individual's impairment and a 'relational' perspective that highlights how people with impairments are subjected to wide-ranging processes of social exclusion. Furthermore, the conventional absorption in 'personal troubles' gave way to a collective sense of injustice: 'We are challenging society to take account of us, to listen to what we have to say, to acknowledge us as an integral part of society itself. We do not want ourselves, or anyone else, treated as second class citizens, and put away out of sight and mind' (Hunt 1966a: 158).

Frank Bowe, in *Handicapping America* (1978), pursues a similar theme when he lists six major barriers to the social inclusion of disabled people. These are architectural, attitudinal, educational, occupational, legal and personal (or everyday problems ranging from few material resources to the stigma of having an impairment). Common experiences of exclusion led to disabled people's growing sense of themselves as an oppressed minority. Thus, the first national survey of disabled people in the United States in 1986 reported significant support for the proposition that disabled people are 'a minority group in the same sense as are blacks and Hispanics' (Harris 1986: 114). Disabled people were increasingly seeking to 'take control of the definitional and interpretative processes so that they can forge their own identities and manage their own lives' (Albrecht 1992: 78).

Building a socio-political model of disability

The criticism of 'able-bodied' society was first codified into a radical, alternative to the individual model by the Union of the Physically Impaired Against Segregation (UPIAS) in Britain. Its manifesto, entitled *Fundamental Principles of Disability* (1976), contains the fundamental assertion that society disables people with impairments, thus directing attention to the impact of social and environmental barriers: 'In our view it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society' (UPIAS 1976: 14).

UPIAS's analysis of the disabling society is built on a clear distinction between impairment and disability (see box 1.1). A medical definition of physical impairment is adopted (and subsequently extended to include sensory and cognitive forms), in contrast to a definition of disability in socio-political terms, as 'the outcome of an oppressive relationship between people with . . . impairments and the rest of society' (Finkelstein 1980: 47).

Box 1.1 UPIAS definitions of impairment and disability

- **Impairment**: Lacking part or all of a limb, or having a defective limb, organ or mechanism of the body.
- **Disability**: The disadvantage or restriction of activity caused by a contemporary social organization which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities (UPIAS 1976: 3–4).

This distinction enables the construction of a 'social model' or a 'social barriers model' of disability (Finkelstein

1993b). The line of causation is redirected. In the individual model, 'disability' is attributed to individual pathology, whereas this social model interprets it as the outcome of social barriers and power relations, rather than an inescapable biological destiny. Thus,

> an inability to walk is an impairment, whereas an inability to enter a building because the entrance is up a flight of steps is a disability. An inability to speak is an impairment but an inability to communicate because appropriate technical aids are not made available is a disability. An inability to move one's body is an impairment but an inability to get out of bed because appropriate physical help is not available is a disability. (Morris 1993b: p. x)

Moreover, instead of an individualistic regime of rehabilitation and personal care services, the 'disabling barriers' diagnosis suggests wide-ranging social changes coupled with alternative forms of service support and provision (Finkelstein 1993b). As Jenny Morris later argued: 'Our anger is not about having "a chip on your shoulder", our grief is not a "failure to come to terms with disability". Our dissatisfaction with our lives is not a personality defect but a sane response to the oppression we experience' (1991: 9).

The impact of socio-political analyses of disability can be dramatic:

> I think I went through an almost evangelical conversion as I realised that my disability was not, in fact, the epilepsy, but the toxic drugs with their denied side-effects; the medical regime with its blaming of the victim; the judgement through distance and silence of bus-stop crowds, bar-room crowds and dinner-table friends; the fear; and, not least, the employment problems. (Hevey 1992: 2)

None the less, the social barriers *model* is only a stepping stone to building a 'social *theory* of disability' (Oliver 1996b: 41). This demands in-depth answers to such questions as: 'What is the nature of disability? What causes it? How is it experienced?' (Oliver 1996b: 29–30). As disability is socially produced, it follows that it displays contrasting forms, both historically and between societies. At the same time, theoretical analysis of the structures and processes that bring about the social exclusion and oppression of people with impairments also identifies the necessary targets for a new disability politics geared to overturning the 'disabling' society (Finkelstein 1980; Oliver 1983; Abberley 1987).

Nevertheless, the scope of this new approach to disability must not be exaggerated:

> The social model is not about showing that every dysfunction in our bodies can be compensated for by a gadget, or good design, so that everybody can work an 8-hour day and play badminton in the evenings. It's a way of demonstrating that everyone – even someone who has no movement, no sensory function and who is going to die tomorrow – has the right to a certain standard of living and to be treated with respect. (Vasey 1992: 44)

Policy definitions and measures

In response to criticism that its approach to disability ignored social factors, including the disadvantages experienced by disabled people, the World Health Organization (WHO) produced its *International Classification of Impairments, Disabilities and Handicaps* (ICIDH) (WHO 1980). It offered the definitions shown in box. 1.2.

Box 1.2 WHO definitions of impairment, disability and handicap

- **Impairment**: Any loss or abnormality of psychological, physiological or anatomical structure or function . . .
- **Disability**: Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being . . .
- **Handicap**: A disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role (depending on age, sex, social and cultural factors) for that individual. (WHO 1980: 29)

In what disabled critics dismiss as a characteristically individual approach, 'impairment' refers to those parts or systems of the body-mind that do not function 'normally', while 'disability' covers those activities that the individual cannot perform as a result of the impairment. For example, blindness is a visual 'impairment' that causes 'disability' or difficulties in reading. The stress is on functional limitations in the performance of basic daily living tasks. These span locomotion, reaching and stretching, dexterity, seeing, hearing, personal care, continence, communication, behaviour and cognitive functioning.

Most of the novelty of the WHO schema lies in the interpretation of 'handicap'. This highlights the social consequences associated with an impairment and/or disability. It raises the difficulties in performing social roles, while acknowledging that these vary across social groups and cultural contexts.

The ICIDH definitions found immediate favour with many social scientists, but provoked considerable criticism from disabled people's organizations. First, the approach relies primarily on medical definitions and uses a bio-physiological definition of 'normality'. It disregards the impact of social criteria in informing judgements about whether body weight and shape, mental distress or cognitive functioning is 'normal' rather than 'pathological'. Moreover, the definition of 'handicap' ignores the social and cultural relativity in role allocation. For example, women might be rated as having a 'disability' but not be 'handicapped' because the society in which they live denies them the opportunity to engage in certain activities because these are not considered appropriate for females (Wendell 1996: 17).

Second, 'impairment' is identified as the cause of both 'disability' and 'handicap'. This privileges medical and allied rehabilitative and educational interventions in the treatment of social and economic disadvantages. It justifies the domination of disabled people's lives by health professionals. In contrast, disabled people increasingly argue that disability (as defined in a social perspective) is not a health issue, and therefore that health professionals are not the appropriate judges of their support needs.

This leads to a third criticism, that the ICIDH represents the environment as 'neutral', and ignores the extent to which disabling social, economic and cultural barriers are significant in the social exclusion of people with impairments. Even though social and environmental influences are recognized, these have little significance or credibility in the application of the ICIDH in service planning or provision. The overwhelming clinical focus dictates strategies for individual adjustment and coping. 'Unrealistic' hopes and ambitions are constrained. Whether a person is born with an impairment or acquires it later in life, the ICIDH reinforces socialization into a dependent role and identity, for lack of any other choice. Certainly, medical and allied interventions have had many positive outcomes for disabled people, but the ICIDH concentrates on diagnosing and treating the individual's 'limitation' rather than that person's social exclusion.

Widespread disenchantment among disabled people and their organizations, as well as criticism from mainstream medical researchers persuaded WHO to revise its classificatory scheme. This resulted in the *International Classification of Functioning and Disability* (WHO 1999), or, more 'popularly', ICIDH-2. It sought to incorporate the 'medical' and 'social' models into a new 'biopsychosocial' approach. The overall result is a 'multi-purpose' classification system that retains the concept of impairment in body function and structure, but replaces 'disability' with activities, and 'handicap' with participation. In addition, ICIDH-2 assumes that functioning, activity and participation are influenced by a myriad of environmental factors, both material and social. This opens up new possibilities for a socio-medical analysis of disablement, although it retains individualistic medical notions of disability and its causes (Hurst 2000).

Notwithstanding these developments, there is ample evidence internationally of the continued acceptance of the individual model of disability in policy circles. Thus, the 'functional limitations' approach is widely incorporated within anti-discrimination legislation (as in the USA and Britain), and it continues to inform surveys of the prevalence of 'disability' within the European Union (Barnes et al. 1999; European Commission 2001).

Issues and themes

C. Wright Mills (1970) argued that the sociological imagination has a particular contribution to make in helping us see how some seemingly 'personal troubles' are more appropriately understood as 'public issues' that link to the institutions of society as a whole (p. 14). The basic aim is 'to see the *social* in the *individual*, the *general* in the *particular*' (Bauman 1990: 10). The realization that apparently 'natural' features of society are both sustained and revised by human action allows for the possibility of 'alternative futures' (Giddens 1982: 26).

It is our task to demonstrate the merits and potential of social analyses of disability. This entails addressing issues that arise at individual, social (group) and societal levels (Turner 1987; Layder 1997). Furthermore, as the disability studies literature has grown over the last two decades, the initial dominance of interactionist and minority group perspectives in the USA, and neo-Marxist analyses in the British literature, has been contested. A wide range of disciplinary perspectives and theoretical interpretations, including feminism, post-structuralism and post-modernism, now competes for attention in disability studies.

Most specifically in the chapters that follow, we review key issues and themes in analysing disability. In chapter 2, we equate a 'social model' approach within the analysis of disability as a changing form of social oppression and exclusion. It gives a specific stimulus to historical perspectives on impairment and disability, most notably with the growth of industrial capitalism. This highlights the establishment of professional (especially medical) dominance and the resort to institutional 'solutions'. These trends are exemplified by the emerging discourse around 'normalcy' and difference, including the scientific identification of 'defective' minds and bodies. Chapter 3 outlines more of the contemporary empirical detail required to substantiate claims about disabled people's social oppression. The discussion spans key areas across the 'public' and 'private' domains, including education, paid employment, the built environment, leisure and 'right to life' issues. It also explores how far other social divisions such as gender and 'race' mediate disability as well as any life cycle patterns.

Recent calls to 'bring impairment in' to disability studies are addressed in chapter 4. These have generated intense debate about 'impairment effects', while overlapping with a considerable literature by medical sociologists on the experience and meaning of 'chronic illness and disability'. It merges with a burgeoning interest in difference and identity, and post-structuralist-inspired studies of changing discourses on the body. Cultural representation and the media are examined in chapter 5. This offers a counterweight to the structuralist focus in early social model debates by exploring the negative media images of disabled people that dominate (Western) cultures. We also examine attempts by disabled people to generate a more positive disability identity and culture(s).

Chapter 6 explores the exclusion of disabled people from mainstream political processes and institutions, and the policy responses adopted in liberal democracies, including equal opportunities and anti-discrimination legislation. It also illustrates the emergence of a new 'disability politics'. This raises important questions about how far impairment and/or disability can be the basis for a shared identity or political project, or the basis for a 'new social movement'. Finally, in chapter 7, we bring an important comparative and international dimension to the debates on disability.

Terminology

A critique of established definitions and language has been an understandable obsession for disabled people, given that disabled people's lives are so affected by 'official' definitions and meanings. In our view, widely used English words such as 'cripple', 'spastic' and 'idiot' have lost any semblance of 'technical' meaning and simply become terms of abuse or ridicule. Equally, common metaphors such as 'turn a blind eye' or 'deaf ear' to the world reinforce an impression of incapacity and abnormality. An alternative vocabulary has proved to be a source of endless debate, but here the phrase 'disabled people', rather than 'people with disabilities', is

used because it signals our emphasis on the ways in which social barriers affect life chances. Nevertheless, we concede that key terms, including 'disability' and 'disabled people', often defy easy translation into other languages. Moreover, different historical and cultural experiences often thwart agreement among those who speak a common language, as a cursory glance at the American and British literature confirms.

Review

Academic discussion of impairment and disability in the social sciences has been slow to undercut the prevailing 'personal tragedy' orthodoxy. Socio-political analyses of disability owe their momentum instead to the pioneering studies of disabled activists and the growing politicization of disabled people around the world. A new, vibrant disability studies literature is now building alternative perspectives to the established, individualistic approach to disability. This includes criticism of conventional policy responses to disability as well as mainstream service provision. It has also highlighted the contrasting form and character of disability across specific social, cultural, economic and political contexts. At the same time, the emergence of analyses of disability as a form of social oppression has triggered new demands for political action.