

### Disablism

In this assignment disablism is examined through the theoretical lens of social constructionism. The background and definition of the term disablism is examined. The distinction between impairment and disability is discussed, and the relationship between disability and intersectionality, such as disability and gender and its role as a cause of multiple deprivations, such as social exclusion, stigma, status and poverty are considered. Legislation and other measures intended to challenge disablism is described. Social constructionism has been chosen to explore disablism as influential sociologists such as Oliver (1998) contest that disability and issues that surround it, such as oppression, prejudice and disadvantage are socially constructed phenomena. However, functionalism as a theoretical lens is also described as functionalist sociologist Talcott Parsons (1951) conceptualized the 'sick role' which has influenced sociological perspectives on illness and disability before the advent of the social model of disability (Halambos and Holborn, 2013). The (bio)medical and social models of illness and disability are discussed and contrasted (Halambos and Holborn, 2013). Although social constructionism is the principle sociological means utilised, other theoretical concepts are referred to; functionalism, as described above, positivism as this is influential in the mainstreaming of the biomedical perspective, and critical theory as applied to disability. There are also references to feminist and identity theories in order to explain examples of disablism such as othering, stigma and social capital theories.

Disablism is a type of social oppression affecting people with disability (Thomas, 2010). This oppression takes many forms and affects all levels of society and in social relationships (Yee, 2019), describing social and institutional barriers such as discrimination, prejudice, negative attitudes and physical and social inhibitors to full participation (Thomas 2010). Miller, Parker and Gillinson (2004, p9) define disablism as "Discriminatory, oppressive or abusive behaviour arising from the belief that disabled people are inferior to others." However, although the term was conceptualized in the 1970's it is not in widespread use (Miller et al, 2004). A Google search on 10<sup>th</sup> December 2019 of the word 'disablism' returned just 40,000 results compared to '75,900,000' for the word 'disability'. The Council of Europe (2019) has a 7 paged website dedicated to disability, but the subject of disablism is limited to just one paragraph of around 400 words. None of the reference books utilised for this assignment has disablism as a subject in their index, although its use is increasing in academic papers. The BBC (2014) carries a blog which reports on the increasing use within social media of the word ableism as an alternative to the terms disability discrimination or disability prejudice. However, more recently ableism has been used to mean the preferences given to non-disabled people over disabled people, for example, in the provision of services, housing and employment (Scope, 2019). Disablism and ableism therefore, are used as distinct meanings for discrimination of disabled people. Commentators such as Thomas (2010) posit that disablism is comparable with other examples of social oppression such as sexism, racism, ageism and homophobia, however, others, such as Miller,

Parker and Gillinson (2004) argue that disablism is a distinct form of oppression because of the unique embodied nature of disability resulting in the disabled frequently being viewed as objects worthy of pity. Miller, Parker and Gillinson, (2004) argue that a strong label is necessary to challenge embedded negative stereotypes of disabled people and to challenge the concept of someone with a disability as a lesser person. Harpur (2009) argues however, for the preferred use of the word ableism since, arguably, disablism focuses on the disability as a contributing factor to the act of discrimination and therefore focuses on difference rather than the prejudicial nature of the act.

During the latter part of the 20th century policy debates on disability, frequently driven by disability organisations, transformed ideological approaches about the nature of disability (Priestley, 2010). Conventional policy frameworks frequently addressed disability as an individual problem requiring functional treatment, for example through medical or rehabilitation services and care through specialised institutions such as ‘special schools’, ‘homes’, psychiatric hospitals and sheltered employment (Priestley, 2008). In this This approach, known as the (bio)medical model was strongly influenced by the structuralist theories of Talcott Parsons (1902-1979). Structuralism is a branch of sociology concerned with the structure of society and originated through the theories of the founding father of sociology, Emile Durkheim (1858-1917, cited in Haralambos and Holborne, 2013). Durkheim was interested in why societies, barring occasional wars and anomie, remained relatively stable, viewing each structure in society as instrumental to this stability which was compared to bodily organs contributing to homeostasis (Haralambos and Holborne, 2013). In ‘The Social System’ (1951) Talcott Parsons sought to investigate the role of health and illness on the stability of society and proposed the concept of the “sick role” (Haralambos and Holborn, 2013, p.282). Parsons suggested that, rather than having a biological basis illness is a form of deviance from societal norms, which threatens the stability of society (Browne, 2002; Haralambos and Holborn, 2013). Parsons argued that if too many people are ill, society would be threatened as sick people are unable to undertake ‘normal’ social functions, such as going to work, attending school or looking after their family (Browne, 2002). Ill health is therefore something that needs to be constrained through social control to maintain the smooth functioning of society, which, Parsons argues, is fulfilled by the sick role (Browns, 2002), People who are ill, therefore are expected to act in ways which reflect the cultural attitudes of their society; illness is therefore a social role (Haralambos and Holborn, 2013) Parsons suggested, that in Western contemporary society this involves a number of rights and obligations: sick people are excused everyday social roles such as going to work or school or looking after their family, however the sickness must be accepted by others, such as employers, teachers and loved ones otherwise support from an expert such as a doctor is necessary, such as through a sick-note. Secondly, the sick person is not responsible for their illness and can expect care from others and is therefore absolved of their deviance. However, these sick role ‘rights’, also bring obligations; the

sick person must recognise their deviance as undesirable, and therefore want to get well. To this end, ill people are expected to seek medical help and follow doctors' orders in order to return to health (Haralambos and Holborn, 2013; Browne, 2002). The sick role model is subject to a number of criticisms; for example, it is not considered useful in chronic or incurable illnesses, or in disability. In response to this Safilios-Roschild (1970, cited in Haralambos and Holborn, 2013) proposed a concept of the 'Rehabilitation Role' which provides a social role for disabled and chronically ill people which involves a person accepting and accommodating their condition by achieving and maximizing their abilities, and, importantly by cooperating with medical and rehabilitation services.

Oliver (1990) rejects this role theory and the medical model of disability which he argues has led to an 'ideology of personal tragedy' towards those with impairments. The tragedy envisioned is the perception that a disabled person has undergone some personal tragedy that has ruined their life, and with which they must do their best to cope with (Oliver, 1990). This view has become so accepted that it has been adopted as fact in wider society, becoming the hegemonic attitude and influencing social attitudes and social policy. (Oliver, 1990). Consequently, Oliver (1990) believes that this led to disabled people being viewed as deserving of pity and financial assistance and other welfare provision through social security to compensate them for their 'limitations.' However, during the latter part of the 20<sup>th</sup> Century the debate moved to one of recognising human rights and the removal of barriers to full social participation (Priestly, 2008). Consequently, a radically different view of disability became prominent which can be traced to an ideological leap by The Union of the Physically Impaired Against Segregation (UPIAS) and the Disability Alliance which, in 1975, jointly produced a position paper titled 'Fundamental Principles of Disability' (Shakespeare and Watson, 2002; UPIAS, 1975). This paper, described by Hasler (1993) as "the big idea of the disability movement" (cited in Shakespeare and Watson, 2002, p3). This radically different view led to disability being recognised, not as the personal limitation that an individual with impairment may have, requiring interventions to restore 'normal' bodily functions, but as a social and political problem requiring solutions to challenge the discrimination which is disabling (Priestley, 2010; Oliver 1998). This radically alternative approach is named the social model of disability (Priestley, 2008), or social oppression theory of disability (Oliver, 1998). The opening paragraph of the UPIAS and Disability Alliance paper puts this alternative approach succinctly:

Fundamental principles to which we are both in agreement: disability is a situation, caused by social conditions, which requires for its elimination, (a) that no one aspect such as incomes, mobility or institutions is treated in isolation, (b) that disabled people should, with the advice and help of others, assume control over their own lives, and © that professionals, experts and others who seek to help must be committed to promoting such control by disabled people.

(The Union of the Physically Impaired Against Segregation and Disability Alliance, 1975)

Shakespeare (1998) suggests that disability should be viewed as a social construction; a problem which is created through the attitudes and values of society and not by the condition of individuals' bodies, psychology or mental health. Disability is created by a society which does not take account of the needs of those who do not meet the societal 'ideal type' of what is normal (Shakespeare, 1998). Whether someone is disabled or not is, therefore, a social product and it is societal attitudes which create a disability from an impairment, through discriminatory behaviour (Shakespeare, 1998). For example, the Council for Europe (2019) suggests that most people would not consider themselves prejudiced against disabled people, but many drivers continue to park in designated disability parking areas and on pavements causing an obstruction for those using wheelchairs, mobility scooters or other mobility aids. The dualism of impairment and disability (Shakespeare, 1996) is also important when considering the fact that many, if not most, people have some form of impairment; for example, eyesight problems, particularly shortsightedness, longsightedness and presbyopia are extremely common, as evidenced by the number of opticians on the High Street. However, these problems only become a disability if people are unable to access spectacles or contact lenses to correct the problem; people with short-sightedness may not be allowed to drive or undertake activities where good vision is necessary or may not be able to recognise people and things at a distance, those with longsightedness may not be able to read if documents, books and newspapers are printed in small print (Browne, 2002). Such impairments may seem relatively minor in societies such as the UK, but it demonstrates that in poorer communities which do not have access to glasses, incidences of disability through such impairments will be much higher (Browne, 2002). Workplaces can be disabling if the work environment, including practices, do not take account of an employee's impairment, and adjustments made where necessary to allow the person to perform their role successfully (Browne, 2002)

Michael Oliver (1996) furthers this description of the social model of disability:

Disability, according to the social model, is all the things that impose restrictions on disabled people; ranging from individual prejudice to institutional discrimination, from inaccessible buildings to unusable transport systems, from segregated education to excluding work arrangements, and so on. Further, the consequences of this failure do not simply and randomly fall on individuals but systematically upon disabled people as a group who experience this failure as discrimination institutionalised throughout society.

Oliver (1996)

Oliver (1998) also further emphasises the importance of definitions in disablism. The social model of disability makes clear distinctions between impairment and disability (Oliver, 1998). Impairment is described as any functional limitations of an individual whilst disability is the range of constraints faced by individuals to participate in society at an equal level due to social and physical barriers (Oliver, 1998). Shakespeare and Watson (2002) describe this dualism implicit in the social model as being very liberating to those with impairment from the constraints that they were at fault for their impairment; that it is only social change that will truly liberate people from disablism.

Oliver (1998) also points out that although disability is a social issue, doctors, largely, still retain powerful gatekeeping roles for, for example in facilitating or influencing access to welfare benefits, disability service and housing (Oliver, 1998). Oliver (1998) points out that although disabled people may become ill, and illness may cause disability, disability itself is not an illness and this medicalisation of disability

Some theorists, however, criticize what is seen as the rigidity of the dualism of impairment and disability implicit in the social model, and the issue of identity of disability (Shakespeare and Watson, 2002). Arguing that the social model has become a 'shibboleth' of the disability movement, Shakespeare and Watson (2002) argue that the social model as an all-encompassing schema fails to recognise the everyday pain, discomfort and limitation of impairment that is the reality of some disabled people's lives and argue for a more adequate theory of disability (p.26) recognising that impairment and disability lie on a continuum. It is also argued that the social model does not adequately reflect the experience of those with multiple inequalities; For example, despite social policies aimed at removing the barriers to employment most disabled people live in poverty, women are less likely to claim disability benefits and are still largely expected to adopt the housewife role (Oakley, 1974).

As has been seen above, disablism often identifies with social and physical barriers and the behaviours and attitudes of a naïve or uncaring society (Oliver, 1998). However, there are other examples of disablism which are not so evident; othering, stigma and lack of social capital are examples.

Othering is a process of identifying people or groups of people through their social identities and marginalizing them because of their difference, thereby propagating inequalities, injustice and other social problems (Powell and Menendian, 2016, Zevallos, 2011). Zygmunt Bauman, (cited in Zevallos, 2011) argues that in (western) societies, identities are established in dichotomies which are fundamental to the way in which society establishes identities, for example; man/woman, male/female, teacher/pupil, able/disabled, In her seminal feminist treatise 'The Second Sex', de Beauvoir (1949) explains how, by becoming a woman, woman becomes the other of man, and by

being identified as the other becomes objectified, and as the objectified other is subordinate to the other (man). As the other of man, woman is defined in relation to man and is marginalized because of the hegemony of man through social forces such as patriarchy (de Beauvoir, 1949). Due to the hegemony of the ideal type, that is, the non-disabled, those identified as disabled become marginalized and discriminated against because of their perceived difference from the norm (Haralambos and Holborn, 2013).

Stigma is defined as physical or social characteristics which are identified as warranting social disapproval, resulting in a range of social responses such as marginalization, prejudice and vilification (Giddens and Sutton, 2018). Stigma probably originated as a social control to individuals with difference who were blamed for their deviation from the norm, for example for past life discretions (Bond, 2017). Blame for various social characteristics still persists because of the dominance of the medical model which insists that lifestyle and choice impact on health; HIV/Aids, obesity and lung cancer are examples (Haralambos and Holborn, 2013). Goffman (1963) theorized how stigmatizing processes produce discrimination, and how the stigmatized person might respond to protect and maintain their sense of self. Hunt (1966), however, argued that stigmatizing of disability results, not from an individuals' impairments, but from interactions with others. However, Charlton (1998, cited in Haralambos and Holborn, 2013) criticizes these approaches to the concept of stigma when applied to disability, arguing that real world 'structural' problems, such as exclusion from employment and poverty are central to the experience of disability. According to Bordieu (1984), however, stigmatization of disability leads to lower levels of physical and symbolic capital, whilst poverty results in lower levels of economic capital which exacerbates inequality. Bordieu (1984) also argues that the powerful position of the institution of medicine, which forms a sense of place and being in society (habitus) creating an idea and expectation of inferiority and dependency, which Bordieu (1984) argues is a form of symbolic violence.

Since social identities are fundamentally important to the issue of oppression and marginalization if disabled people, it is worth considering how the identity of 'disabled person' emerged. Priestley (2008) argues that before the development of welfare people with impairments were not distinguished from the general population, although they may have been marginalized, and destitute. With industrialization and urbanization however, distinction was made between a productive and non-productive workforce and those who were unable to work were seen as being entitled to limited welfare (Priestley, 2008). Disability therefore became an "administrative category" (Priestley, 2008, p404) for the control of labour and access to welfare. Foucault (1980) provides an example of the emergence of new identities through social developments with the creation of the taxonomies of 'homosexual' and 'heterosexual' in the mid 19<sup>th</sup> century. Finkelstein (1980) argues that during

industrialization people with impairments came to be seen as different from the ‘normal’ able bodied population which led to marginalization and exclusion. Many impairments became medicalized during this period and specialized institutions grew to treat and care for these newly identified disabled, which Finkelstein points out lasted until well into the twentieth century which takes us back to the medical model. However, Shakespeare (1994) disagrees with Finkelstein, arguing that prejudice towards disability results from ‘cultural representations in language and socialization’, and that such prejudice was evident before industrialization, for example in the description of ‘cripples’ and the provision of alms.

The categorization of disability, as Priestley (2008) points out, has been considered necessary for the provision of welfare. Problems of defining disability continues today. The position of Oliver (1990) that barriers are the cause of disability, technically people move in and out of disability, which of course is nonsensical. Also, different societies see impairments in different ways, as a study of how various societies respond to sight loss shows; counselling, physical aids, religious communion (Priestley, 2008). Disability therefore remains a cultural issue.

Finally, as has been shown with the emergence of the social model of disability the move has been from treatment and ‘normalization’ to recognising individual’s rights and freedoms (Priestley, 2008). This has been a global phenomenon and in 2006 the United Nations passed the Convention on the Rights of Persons with Disabilities intended to protect the rights and dignity of people with disabilities. In December 2009 the United Nations held a conference in Doha, Qatar, on Disability and Development.

The UK has responded to these social developments with laws specifically guaranteeing the rights of those with disabilities, such as the NHS and Community Care Act (1990) which gave the responsibility for assessing people’s needs to local authorities, and the Disability Discrimination Act (1995), which established the legal definition of disability in the UK but which gave limited protection to disabled people, and which has been consolidated with Equality Act 2010.

Finally, in the UK someone is disabled if they “have physical or mental impairment that has a substantial and long-term negative affect on their ability to do normal daily activities (Equality Act, 2010).

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