The Disability Studies Reader

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A Brief History of Discrimination and Disabled People

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To appreciate fully the extent and complexity of the discrimination experienced by disabled people in modern Britain an understanding of history is critical. Consequently the main objectives of this chapter are to draw attention to the philosophical and cultural foundations of discrimination; to outline briefly the discriminatory practices and policies of the past; and to show how they have influenced current British attitudes and institutions.

EARLY INFLUENCES

To pinpoint precisely the origins of society's attitudes toward disability and disabled people would be almost impossible. Among the many suggestions that have been made is the view that our perceptions of impairment and disability are coloured by a deep-rooted psychological fear of the unknown, the anomalous and the abnormal (Douglas, 1966). It is widely acknowledged, however, that our perceptions of normality are partly if not wholly determined by others through learning and the natural transmission of ideology and culture. Here ideology and culture both refer to a communally accepted set of values and beliefs which influences the perceptions of individuals. It provides in advance some basic categories and a set of rules in which ideas and values are formed. Above all, 'it has authority, since each is induced to assent because of the assent of others' (Douglas, 1966). While individual perceptions and ideas vary slightly, cultural concepts are usually more rigid.

Some writers have suggested that cultural intolerance of disability and disabled people can be explained by reference to the economy. For example, our distant ancestors lived in such a harsh environment that there was little opportunity to support individuals with impairments who could not take care of themselves (Thomas, 1982), but with the advent of relatively stable communities able to produce an economic surplus through the development of agriculture, such an analysis becomes difficult to sustain. Indeed there is sufficient historical and anthropological evidence to show that there is no universal approach to disability, either in the way disabled people are perceived or in the way societies respond to them (see Hanks and Hanks, 1980; Oliver, 1981, 1990). Consequently explanations which rely solely on the economy are untenable; cultural factors must be considered also.

In the cultural precursors to our own society, however, there is evidence of a consistent bias against disability and disabled people which has only recently been seriously challenged. Examples can be

found in religion, Greek philosophy and European drama and art since well before the Renaissance.

In the Old Testament much of Leviticus is devoted to a reiteration of the physical and mental perfections deemed necessary for all aspects of religious ritual (Lev. 21.16–20). Indeed, only lately have people with learning difficulties been allowed to receive some sacraments in the Roman Catholic Church. Moreover, while the ancient Greeks and Romans placed a high priority upon the care of those injured and subsequently disabled in battle, they were enthusiastic advocates of infanticide for sickly or deformed children. In Sparta these policies were demanded by law (Tooley, 1983).

Throughout the Middle Ages disabled people were the subject of superstition, persecution and rejection. Haffter (1968) has pointed out that in medieval Europe disability was associated with evil and witchcraft. Deformed and disabled children were seen as 'changelings' or the Devil's substitutes for human children, the outcome of their parents' involvement with the black arts or sorcery. The *Malleus Maleficarum* of 1487 declared that these children were the product of the mothers' intercourse with Satan. The idea that any form of physical or mental impairment was the result of divine judgement for wrongdoing was pervasive throughout the British Isles in this period. And the association between disability and evil was not limited to the layman. Protestant reformer Martin Luther (1483–1546) proclaimed that he saw the Devil in a profoundly disabled child. If these children lived, Luther recommended killing them. They were the focus of a mixture of emotions which embodied guilt, fear and contempt.

William Shakespeare's *Richard III* illustrates clearly the attitudes that would be experienced by someone born into a world which placed a high premium upon physical normality:

Cheated of feature by dissembling nature,
Deformed, unfinished, sent before my time
Into this breathing world, scarce half made
  up,
And that so lamely and unfashionable
The dogs bark at me as I halt by them.

Shakespeare portrays Richard as twisted in both body and mind. Since he cannot succeed as a lover because of his deformity he is determined to succeed as a villain. This essentially distorted and inherently negative view of disabled people is evident in a great deal of literature and art, both classical and popular, and continues to be produced today (see Gartner and Joe, 1987).

Mental and physical impairments were also primary targets for amusement and ridicule during the Middle Ages. And Thomas' (1977) analysis of the joke books of Tudor and Stuart England reveals the extent of this dimension of the discrimination encountered by disabled people. Besides references to the other so-called timeless universals of 'popular' humour such as foreigners, women, and the clergy, there are many jokes about impairment and disabled people:

> Every disability from idiocy to insanity to diabetes and bad breath was a welcome source of amusement, 'we jest at a man's body that is not well proportioned', said Thomas Wilson, 'and laugh at his countenance . . . if it be not comely by nature'. A typical Elizabethan joke book contains 'merry jests at fools' and merry jests at 'blind folk'. While some of the tricksters' pranks are brutal to the extreme. (Thomas, 1977, pp. 80–1)

Visits to Bedlam were also a common form of amusement for the socially well placed and the practice of keeping 'idiots' as objects of entertainment was prevalent among the aristocracy (Ryan and Thomas, 1980). As we shall see later, disabled people are still the focus for much of what passes as comedy.

Until the seventeenth century those disabled people who were rejected by their families, along with other disadvantaged groups such as the sick, the elderly and the poor, relied almost exclusively on the haphazard and often ineffectual tradition of Christian charity and alms-giving for subsistence. They were rarely gathered together under one roof, however. Despite disenfranchising them from religious ceremony, Christianity, in keeping with the other major western religions, has always acknowledged a responsibility for disabled people. Individuals with severe impairments were usually admitted to one of the very small medieval hospitals in which the sick and bedridden poor were gathered. But the ethos of these hospitals was ecclesiastical rather than medical; they were dedicated to 'care' rather than 'cure' (Scull, 1984).

During the sixteenth century the wealth and power of the Church was greatly reduced because of a series of unsuccessful political confrontations with the monarchy. There was also a steady growth in the numbers of people seeking alms. This was due to several factors, including a growth in the population after a period of stagnation and depletion due to plagues, the beginnings of the commercialisation of agriculture, successive poor harvests, and an influx of immigrants from Ireland and Wales (Stone, 1985). Hence the fear of 'bands of sturdy beggars' preyed on the minds of local magistrates, who demanded a response from the central authority, namely the Crown (Trevelyan, 1948). To secure their allegiance, the Tudor monarchs were forced to make economic provision for people dependent upon charity. Consequently the Poor Law of 1601 marks the first official recognition of the need for state intervention in the lives of disabled people.

A general suspicion of those claiming alms, however, had already been formally established with the statute of 1388 which mandated local officials to discriminate between the 'deserving' and 'undeserving' poor. But although people with impairments were among the 'deserving poor', there was little attempt to separate them from the rest of the community. On the contrary, every effort was made to keep them within the local environment.

Although there was some parochial variation in the actual level of benefit, there was a degree of uniformity in the way disabled people were treated. The lion's share of resources was directed toward domestic or 'household relief' for people who were regarded as unable to work and were confined to the home. Funds were frequently provided to individuals and families willing to accept responsibility for people considered to be incapable of looking after themselves. Major changes to this essentially non-segregationist policy did not begin to be discussed or implemented until the nineteenth century.

However, a clear insight into society's general attitude toward disabled people during this period can be gleaned from an essay written by William Hay in 1754. Born in 1695, Hay was a typical gentleman of the period, a country squire, a Justice of the Peace and a Member of Parliament. He wrote an autobiographical essay titled *Deformity* one year before his death, which is in essence a heartfelt philosophical analysis of disability: a subject of which he had personal experience.

Hay describes himself as barely 5 feet tall with a back 'bent in my mother's womb'. His essay is an outline of the socio-psychological difficulties he experienced because of his impairment. He believed it had caused him to be bashful, uneasy and unsure of himself. He was extremely conscious of his personal appearance and considered himself very fortunate to have been born into a social class where a high emphasis was placed on good manners and politeness. This prevented any 'gentleman' from making derogatory remarks concerning his stature. He noted,

however, how the gentle 'friendly' teasing of his close friends contrasted sharply with the treatment of disabled people by society at large, 'where insolence grows in proportion as the man sinks in condition' (Hay, 1754, quoted in Thomas, 1982, p. 62).

INDUSTRIALISATION AND AFTER

Throughout the eighteenth and nineteenth centuries the policy of segregating severely disabled people into institutional settings slowly increased and was subsequently extended to other disadvantaged groups. Although the term 'institution' can be used to refer to a variety of social organisations ranging from the family to a university, it refers here to 'any long term provision of a highly organized kind on a residential basis with the expressed aims of "care", "treatment" or "custody"' (Jones and Fowles, 1984, p. 207). They include hospitals, asylums, workhouses and prisons.

One explanation for this important break with the past links it to the breakdown of early forms of state welfare in the face of large-scale urban industrialisation and the inevitable spread of poverty which followed (Mechanic, 1964). But the impetus to build institutions came before the growth of cities and was more pronounced in rural communities (Ingelby, 1983). A variation on this theme, however, suggests that the widespread incarceration of disabled people is directly attributable to the transition from agriculture and cottage-based industries to the large-scale factory-type system:

> The speed of factory work, the enforced discipline, the time keeping and production norms—all these were a highly unfavourable change from the slower, more self-determined and flexible methods of work into which many handicapped people had been integrated. (Ryan and Thomas, 1980, p. 101)

Although such arguments tend to play down the general antipathy which sur-

rounded disability before the Industrial Revolution, it is clear that the economic and social conditions created by the new system compounded the difficulties faced by disabled people. First, a family dependent upon waged labour alone could not provide for its members during economic depression, so that large groups of dependents were created by industrialisation. Secondly, the system of Poor Law relief which had survived since Elizabethan times was directly at odds with the ascending free market economy. Waged labour made the distinction between the able-bodied and the non-able-bodied poor crucially important, since parochial relief to the able-bodied poor interfered with labour mobility.

Segregating the poor into institutions, on the other hand, had several advantages over domestic relief; it was efficient, it acted as a major deterrent to the able-bodied malingerer, and it could instil good work habits into the inmates (Ingelby, 1983). These conclusions are clearly reflected in the Report of the Poor Law Commission and the Poor Law Amendment Act of 1834. The 1834 reforms introduced three new principles for state welfare policy: national uniformity, denial of relief outside an institution, and deterrence as the basis for setting the levels of welfare benefits.

Uniformity of provision was considered important in order to discourage potential workers from moving from one parish to the next in search of better benefits. Moreover, since aid was set at subsistence level only, uniformity would encourage people to move where the work was in the search for a better standard of living. As early as 1722 Parliament had granted local authorities the right to refuse benefit or outdoor relief to anyone unwilling to enter a workhouse, but the 1834 Poor Law reforms expressly endorsed it, although this instruction was never fully implemented.

Deterrence was evident in the principle of 'least eligibility' whereby a pauper's

situation should be less comfortable than that of an 'independent labourer of the lowest class' before benefits could be granted. The workhouse was intended to be as unpleasant as possible so that no-one would enter it willingly. Families were broken up, inmates were made to wear specific uniforms, there were no recreational facilities and socialising was strictly forbidden in working hours. Routines were rigidly enforced and food was limited to what was considered necessary for survival and work.

Besides the horrors of institutions, described so vividly in the novels of Charles Dickens, the nineteenth century was also significant for an upsurge of Christian morality and humanitarian values which were to have a profound effect upon the lives of disabled people. A mixture of religious altruism and conscience, this spirit of Victorian patronage put an end to the widespread practice of infanticide for disabled children, which had hitherto been the rule rather than the exception (Tooley, 1983). It also stimulated some Victorians to question seriously the harsh treatment meted out to people who were generally considered incapable of finding work. When combined with the institutionalised mistrust of people claiming charity, these philanthropic ideals set in motion a process of differentiation which not only separated disabled people from other disadvantaged sections of the community, but also divided them up into specific categories and groups, with differing treatment for each group. The legacy of this policy remains with us today.

From the outset the Poor Law Commission decreed that the workhouses should separate the incarcerated population into four different groupings, namely able-bodied males, able-bodied females, children, and the 'aged and infirm'. It was intended that the latter, or those perceived as the 'deserving poor', were to be housed in different buildings and accorded different treatment. In the following years these categories were refined still further. Aided by the burgeoning medical profession, Poor Law Officials developed four specific categories for dealing with the non-able-bodied poor. They were the 'sick', the 'insane', 'defectives', and the 'aged and infirm' (Stone, 1985).

The term 'sick' described people with acute, temporary or infectious diseases. This group often automatically qualified for outdoor relief if it was available. But where incarceration was deemed necessary, separate accommodation was usually provided, although the conditions in these facilities were rarely better than those in the workhouse. Illness and impairment could not be seen as a route to better treatment, or it would discourage the poor from making provision for the future, and thus undermine the prevailing philosophy of self-reliance.

The 'insane' were singled out for special treatment from the outset. Despite the difficulties of definition and diagnosis, there was already a universal recognition of the 'problem' posed by people with mental illness. There were two main strategies for dealing with it. People termed 'idiots', 'lunatics', 'mad', 'mentally infirm', or 'suffering from diseases of the brain' (Scull, 1978) were either admitted to an asylum or boarded out on contract to families willing to be held responsible for them.

Several private asylums had been established in the seventeenth century. But the public outcry over the atrocious conditions in many of these establishments, brought to light by Evangelical reformers, forced the Government into setting up a state-run system in 1845. It is important to note, however, that the cruelty accorded to people perceived as mentally ill inside institutions was often no worse than that which they encountered in the community at large (Roth and Kroll, 1986).

Until 1871 Poor Law officials had no right to detain citizens in an institution

against their will, but this did not apply to people termed insane. Prior to the Lunacy Legislation of 1845, the certification of insanity was the responsibility of local lay officials. Following that date confirmation of mental illness was valid only if a doctor was involved. This change has been attributed to doctors' assertions that mental illness had physiological causes and was responsive to medical treatment, and their successful struggle for control within private and public institutions (Scull, 1984). Once defined as mentally ill an individual could be detained on a doctor's recommendation and moved from one institution to another against her/his will. Doctors still retain this power (DHSS, 1987). Hence, 1845 can be seen as the start of the medical profession's subsequent domination of all aspects of disability.

The term 'defectives' was used to describe people with sensory impairments such as blindness, deafness and the lack of speech. After 1903 people with epilepsy and children termed 'mentally subnormal' were also added to this category. Although members of this group were still liable to be put into an institution, and their treatment therein was no different from that of other inmates, they were frequently singled out for special attention by Victorian philanthropists and charities. Many of the charities which exist today were founded during this period. For example, the British and Foreign Association for Promoting the Education of the Blind (now known as the Royal National Institute for the Blind [RNIB]) was formed in 1863 (RNIB, 1990).

'Aged and infirm', the oldest of the four categories, referred to people with chronic illness and/or permanent impairments. While there was little official controversy over their eligibility for outdoor relief, more often than not they too were directed into an institutional setting.

Towards the end of the nineteenth century the pressures to incarcerate people classified as belonging to one of these categories increased dramatically. First, the transition from relatively light industries such as textiles to the much heavier capital goods industries like iron, steel and the railways, in what has been called the 'second phase of industrialization' (Hobsbawn, 1968), further emphasised the importance of physical fitness as a criterion for finding work among working people. Secondly, welfare policies, particularly with regard to outdoor relief, were severely tightened during the 1870s and 1880s due to escalating costs because of rising unemployment after a decade of economic depression which began with the severe winter of 1860/1. This put more pressure on local authorities to apply the 'workhouse test' to anyone seeking aid. Thirdly, there was a further expansion of segregated institutions for the non-able-bodied poor following another set of public scandals and government enquiries exposing the appalling conditions in workhouses (Stone, 1985). The number of disabled people consigned to these establishments rose accordingly, and did not begin to fall until the 1950s (Scull, 1984).

Ideological legitimacy for the intensified oppression of disabled people during the eighteenth and nineteenth centuries can be found in the ascendant egocentric philosophies of the period, which stressed the rights and privileges of the individual over and above those of the group or state, in relation to property rights, politics and culture (Macfarland, 1978). 'Scientific' authenticity was forthcoming in 1859 with the publication of Charles Darwin's *On the Origin of Species*.

Based on Darwin's observations during his voyages on the *Beagle*, this study outlines his monumental theory of evolution, which places great emphasis upon the process of natural selection, the survival of the fittest, the notion that evolution is progress, and that progress is inherently beneficial.

It had an understandable appeal to a society dominated by a relatively small elite of property-owning, self-interested, 'rational' individuals who welcomed any opportunity to justify their newly-acquired wealth, status and power. It was quickly adapted from the biological domain to apply to human societies (see Russell, 1948).

What later became known as 'Social Darwinism' dispelled and allayed the qualms of the rich about not helping the disadvantaged by assuring them that the latter's sufferings were the inevitable price of progress, which could only be resolved through the struggle for existence. Endorsed by a number of eminent intellectuals and academics of the period, these ideas were to have significant political and social repercussions throughout nineteenth- and twentieth-century Europe, and indeed the world.

Out of the general tendency to apply Darwin's theories to human affairs emerged the Eugenics movement. Concerned mainly with what they saw as racial degeneration through the birth of disabled children, the Eugenicists reiterated ancient fears that disabled people were a serious threat to British and European society. The work of Galton (1869), Dugdale (1910) and Goddard (1912) reinforced traditional myths that there were genetic links between physical and mental impairments, crime, unemployment and other social evils (see Sapsford, 1981). The stated aim of the Eugenicists was to improve the British race by preventing the reproduction of 'defectives' by means of sterilisation and segregation.

In 1896 the National Association for the Care and Control of the Feeble-Minded was set up as a pressure group for the lifetime segregation of disabled people. During the 1910 general election it campaigned vigorously on these issues. In the following two decades Eugenic fears were further endorsed by the invention and widespread use of Intelligence Quotient (IQ) tests in British schools. Their inventors, the French psychologists Binet and Simon, and principal advocates, notably the psychologist Cyril Burt, asserted confidently that intelligence is innate and that the majority of defectives were ineducable. Moreover, despite the fact that there are serious doubts about the validity of IQ-type tests as objective measures of intelligence (since they measure only a comparatively small range of human qualities, the nature of which is culturally determined [Tomlinson, 1981]) similar techniques are used today to separate the 'normal' from the 'subnormal'.

Eugenic fears were prevalent throughout the 1920s and 1930s. For example, the Report of the Departmental Committee on Sterilization chaired by Lord Brock recommended legislation to ensure the 'voluntary' sterilisation of 'mentally defective women' (Ryan and Thomas, 1980). Although such legislation was never actually passed in Britain (unlike America, where sterilisation became compulsory in a number of states), this has not prevented many such operations being carried out under various forms of coercion. Only recently a 36-year-old 'voluntary' patient in a mental hospital, who was described as 'mentally handicapped', was sterilised without her consent after she had developed a relationship with a male patient which 'probably' involved sexual intercourse or 'something close to it' (Morgan, 1989). The operation was justified on the grounds that the woman would be unable to cope with pregnancy or motherhood.

Eugenic ideals reached their logical conclusion during the 1939–45 war with the extermination of between 80,000 and 100,000 disabled people by the Nazis (Wolfensberger, 1980). But while the atrocities of the Nazi death camps put an end to the overt persecution of disabled people throughout Europe, there remains tacit support for comparable ideas among some sections of the British population, notably

supporters of the National Front (Ryan and Thomas, 1980).

Moreover, research on human foetuses has recently been officially sanctioned by Parliament, partly on the basis that it might prevent the birth of disabled children (*Hansard*, 1990c). It is not uncommon, although rarely discussed openly, for some doctors with the compliance of parents to allow 'severely' impaired babies to die if the impairment is unexpected (Shearer, 1981). And it is considered socially acceptable for British women to have an abortion if there is any 'substantial risk' that the unborn child will be 'seriously handicapped' (HMSO, 1989), although 'seriously handicapped', is rarely defined. In addition, disabled children are more likely to be abandoned by their parents than their able-bodied peers, they have less chance of being adopted (Burrell, 1989), and they are more prone to physical and sexual abuse (Kennedy, 1989; Watson, 1989).

THE IMPACT OF THE WELFARE STATE

With the inception of the welfare state during the 1940s, official policy with regard to disabled people moved away from the extremes of earlier epochs in favour of a more overtly paternalistic approach. This can be explained with reference to a number of factors, including the humanitarian influence of the Victorian philanthropists, the general concern felt toward disabled ex-servicemen during and after the 1914–18 and 1939–45 wars, the changing political climate, and the prospect of a buoyant economy.

A number of welfare and training schemes had been set up for war casualties after the 1914–18 conflict. An expansion of these and similar facilities was recommended by the Tomlinson Report of 1941 (Schlesinger and Whelan, 1979). Moreover, the economic and social upheavals brought about by the depression of the 1930s, in conjunction with the need for national unity during and immediately after the 1939–45 war, stimulated among many politicians a concern for welfare programmes which had hitherto been absent (Doyal, 1980).

This resulted in a flurry of legislation which was to have a significant impact on the lives of disabled people. Indeed the first Act of Parliament to treat disabled people as a single group was the Disabled Persons (Employment) Act of 1944. As well as attempting to ensure that employers employed disabled people, this Act made provision for a variety of rehabilitation services and vocational training courses. The 1944 Education Act stated that every child should receive education suitable for her/his age, ability and aptitude, and obliged local education authorities to provide special educational treatment for those thought to need it. The National Health Service Act 1948 provided for the acute medical needs of disabled people, and made it possible for local authority health departments to provide any medical aids necessary to enable disabled people to live in their own homes. Finally, the National Assistance Act of 1948 made some provision for meeting the financial needs of disabled people, and mandated local authorities to provide residential facilities and services for people 'who are substantially and permanently handicapped by illness, injury or congenital deformity' (quoted in Oliver, 1983).

Since the late 1950s there has been a concerted attempt by successive governments to reduce the numbers of people living in segregated institutions by expanding community-based services. The origins of the use of the phrase 'community care' can be found in the Report of the Royal Commission on Mental Deficiency of 1954–7, which considered the problems arising from outdated mental hospitals and the stigma associated with in-patient treatment. Although there was no precise

definition given, subsequent government statements and documents on services for disabled people have increasingly used the term. It should be noted, however, that the phrase has different meanings for different groups of people and is discussed in more detail in Chapter 6.

The shift toward community-based services took a more decisive turn in 1961 when the Government announced its decision to halve the number of beds in mental hospitals, a move which prompted a number of critics to argue that the motives behind this change in policy were economic rather than humanitarian. One commentator, Titmuss, challenged the Government to refute this allegation, but there was no official reply. In 1962 the Ministry of Health published *A Hospital Plan*. This was followed one year later by *Health and Welfare: The Development of Community Care*, generally referred to as *The Community Care Blue Book*.

These two documents provided a sketchy outline of plans for community-based services, including proposals for increases in the numbers of general practitioners, home helps, district nurses, health visitors, sheltered housing schemes and sheltered workshops. Provision was intended for four specific groups, namely mothers and children, the elderly, 'the mentally disordered' and the 'physically handicapped' (Jones *et al.*, 1983).

Around this time a number of critical investigations into institutional life by social scientists was published (see for example Barton, 1959; Goffman, 1961; Miller, and Gwynne, 1972; Townsend, 1967). In addition, there was a spate of sensational public expositions by the national press of the cruelty and harsh treatment manifest in institutions for 'the elderly' and 'the mentally ill'. All were subsequently investigated and in one particular case, the Ely enquiry, criminal proceedings were brought against hospital personnel (Jones *et al.*, 1983).

As a result of these enquiries, public and in some cases professional confidence in the services provided in long-stay hospitals and similar establishments was again seriously undermined. Local authority services, on the other hand, remained relatively unscathed and underdeveloped. Consequently the pressure to reduce the numbers of people in institutions run by the health service intensified while local authorities were encouraged to expand their facilities accordingly.

There was little agreement as to what services should be provided or where the money to fund the expansion should come from. Extensive variation characterised provision at the local level and budgets were already stretched due to two main factors. The first was the rising expectations of the general population after the setting up of the welfare state, and the second a steady increase in the numbers of 'dependent' people after the 1939–45 war. These included children, people over retirement age, and disabled people.

In an effort to develop and rationalise social service provision at the local level, the Government set up a commission of inquiry which published its findings in 1968. The Seebohm Report is generally considered a watershed in the development of community-based services for disabled people. Among its principal conclusions were the recommendations that local authorities should accumulate data relating to the nature and size of the problems associated with disability; and that they should develop and/or expand services in conjunction with those already provided by the health service and the voluntary sector. These recommendations were subsequently incorporated into the Local Authority Act 1970 and the Chronically Sick and Disabled Persons Act 1970. The establishment of social service departments in their present form quickly followed.

In conjunction with provision for the

other main dependent groups, the new departments were responsible for social services for disabled people. These included the provision of social workers, occupational therapists, residential and day centre facilities, holidays, meals on wheels, respite services, and disability aids and adaptations. This resulted in the situation where almost every aspect of life for a disabled person had its counterpart in a profession or voluntary organisation. Indeed one study estimated that there could be as many as twenty-three professional helpers involved in the life of one disabled person (Brechin and Liddiard, 1985).

Clearly the positive effects of this expansion are that the majority of disabled people now have more access to, relatively, more services and, on the whole, are less likely than, say, before the 1939–45 war to be consigned into a segregated residential setting. On the other hand, the organisation of these services risks their being sucked into a 'culture of dependence' which is predicated upon the assumption that individuals with impairments are people who are helpless and unable to make their own decisions and to choose for themselves the aids and services they need (Shearer, 1981). This is largely due to the fact that the majority of professionals and service-providers adhere either explicitly or implicitly to the traditional individualistic medically-influenced definitions of disability (Davis, 1986; Oliver, 1983; Sutherland, 1981).

From the late 1950s onwards there has been a general tendency by government agencies to reduce the various categories of disability into one all-embracing conceptual framework. This revision was more pronounced in the 1960s, when it became clear that there was insufficient data available to facilitate the proposed expansion of services and to cost the development of new social security benefits. Accordingly the Office of Population, Censuses and Surveys (OPCS) was contracted by the Government to undertake a national disability survey. Findings were published by Harris in 1971 (Harris, 1971).

Harris used functional assessments of disability based on a threefold distinction between impairment, disability and handicap. Similar work was completed by Wood in 1981 (Wood, 1981) for the World Health Organization (WHO). Known as the International Classification of Impairment, Disability and Handicap (ICIDH), Wood's model was used in the second OPCS disability survey carried out during the 1980s (Martin, Meltzer and Elliot, 1988).

This approach remains close to medical classifications of disease. It conserves the notion of impairment as abnormality in function, disability as not being able to perform an activity considered normal for a human being, and handicap as the inability to perform a 'normal' social role (Oliver, 1990). Clearly this model is based upon assumptions about mental and physical normality. It assumes that disability and handicap are caused by psychological or physiological abnormality or impairment, and therefore the impairment is the primary focus of attention.

The first major problem with this approach is that psychological and physical normality and subsequently impairments are not easily defined. Definitions are dependent upon temporal, cultural and situational factors. For example, although homosexuality was considered normal by the ancient Greeks, until very recently it was perceived as a mental illness in many western societies. A male adult less than 5 feet tall might be construed as having a physical impairment in modern Britain, although he might be physiologically healthy.

Secondly, the human being is perceived as flexible and alterable while the physical and social environments are assumed to be fixed and unalterable. This is clearly unrealistic since historically humans have always

moulded the environment to suit their needs rather than the other way round.

Thirdly, since psychological and physical impairments are presented as the cause of disability and handicap, it follows that they should be cured by psychological or medical intervention. People with impairments become objects to be treated, changed, improved and made normal.

While medical intervention for treating illness and disease may be quite appropriate, from the perspective of the disabled person it is quite inappropriate for treating disability.

> In the past especially, doctors have been too willing to suggest medical treatment and hospitalization, even when this would not necessarily improve the quality of life for the person concerned. Indeed, questions about the quality of life have sometimes been portrayed as an intrusion upon the medical equation. (Brisenden, 1986, p. 176)

Fourthly, because it is assumed that disabled people must adapt to a hostile environment, they are subjected to all kinds of emotional pressure in the process of adaptation. Those who succeed are sanctified and held up as exemplars of individual will and effort, while the majority who do not are referred to as passive, apathetic or worse (Reiser and Mason, 1990). This has obvious negative psychological implications, which can and often do compound impairment.

Fifthly, these definitions tend to present impairment, disability and handicap as static states. Apart from being inaccurate (Oliver, 1990), this approach creates artificial distinctions and barriers between disabled people and the rest of society (Zola, 1981) which, at best, prolong ignorance and misunderstanding and, at worst, nourish and sustain ancient fears and prejudices.

In short, these definitions not only help to create and perpetuate discrimination in all its forms but also waste valuable resources, both human and financial, 'on a grand scale' (Davis, 1986). Indeed, the fact that disabled people were excluded from participating in a meaningful way from the process of constructing these schemes is an indication of institutional discrimination by professionals. Above all, it is a waste of the most valuable resource of all, namely the perceptions of people who experience disability every day of their lives. It is not surprising therefore that these models are being rejected by a growing number of disabled people and their organisations, including the British Council of Disabled People (BCODP) and Disabled People's International (DPI).

Finally, Oliver (1990) has demonstrated that there is a far more sinister dimension to these schemes. His comparison of two sets of questions relating to the same topics illustrates the point. The first is based on the official individualised definition of disability and was used in the recent OPCS surveys, while the second is constructed on the basis of a social definition.

What complaint causes your difficulty in holding, gripping or turning things?

Have you attended a special school because of a long-term health problem or disability?

Does your health problem/disability prevent you from going out as often or as far as you would like?

Does your health problem/disability affect your work in any way at present?

These questions effectively reduce the problems that people with impairments face in their daily lives to their own personal inadequacies or functional limitations, and could have been reformulated as follows:

What defects in the design of everyday equipment like jars, bottles and tins causes you difficulty in holding, gripping or turning them?

Have you attended a special school

because of your education authority's policy of sending people with your impairment to such places?

What are the environmental constraints which make it difficult for you to get about in your immediate neighbourhood?

Do you have problems at work because of the physical environment or the attitudes of others?

To understand why the first set of questions is intimidating for individual disabled people it is important to know something about the actual research process. In the OPCS surveys, for example, individuals with impairments were visited in their own home by official 'expert' researchers. They were asked a specified sequence of formal questions and there was no opportunity to clarify or discuss their answers. It is hardly surprising then that

> . . . . by the end of the interview, the disabled person has come to believe that his or her problems are caused by their own health disability problems rather than by the organization of society. It is in this sense that the process of the interview is oppressive, reinforcing onto isolated, individual disabled people the idea that the problems they experience in every day living are a direct result of their own inadequacies or functional limitations. (Oliver, 1990, p. 12)

CONCLUSION

It is plain from the above discussion that although economic factors are significant in explaining social responses to and the experience of disability, cultural considerations are equally important. It is also evident that the philosophical and ideological foundations upon which discrimination against disabled people is justified are well entrenched within the core institutions of society.

The data show that there was substantial discrimination against disabled people in Britain prior to industrialisation,

but it was relatively fragmented and took many forms. The economic and social upheavals which accompanied industrial development, however, precipitated discrimination becoming institutionalised throughout society. Indeed, the growing importance of economic rationality, individualism and medical science during this period contributed to and compounded ancient fears and prejudices, and provided intellectual justification for relatively more extreme discriminatory practices, notably the systematic removal of disabled people from the mainstream of economic and social life.

Since the 1939–45 war, however, there has been a general 'softening' of attitudes and a definite attempt to reverse this policy and integrate people with impairments into the community. To facilitate this goal there has been a rapid expansion of community-based services in both the state and private sectors, and a subsequent proliferation of professional helpers. While the positive effects of these developments are not in doubt, it is clear that they rest upon basically traditional perceptions of impairment and disability. Discrimination has not disappeared; it has simply been transformed into more subtle and less obvious forms.

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