

5 ATTITUDES
AND DISABLED PEOPLE
VICTOR FINKELSTEIN



International Exchange of Information in Rehabilitation

MONOGRAPH NUMBER FIVE

**Attitudes and Disabled People:
Issues for Discussion**

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International Exchange of Information in Rehabilitation

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PREFACE

ABOUT THE INTERNATIONAL EXCHANGE OF INFORMATION IN REHABILITATION:

In order to put this particular piece of writing into perspective, it is important first to cite the legislation to which the International Exchange of Information in Rehabilitation is responsive:

REHABILITATION ACT 1973

REHABILITATION, COMPREHENSIVE SERVICES, AND DEVELOPMENTAL DISABILITIES AMENDMENTS OF 1978 RESEARCH

Section 202(b)5.

Conduct of a program for international rehabilitation research, demonstration, and training for the purpose of developing new knowledge and methods in the rehabilitation of handicapped individuals in the United States, cooperating with and assisting in developing and sharing information found useful in other nations in the rehabilitation of handicapped individuals, and initiating a program to exchange experts and technical assistance in the field of rehabilitation of handicapped individuals with other nations as a means of increasing the levels of skill of rehabilitation personnel.

To develop this project and implement the law, a series of considerations were addressed by the World Rehabilitation Fund. These considerations took into account the following: (1) What are the knowledge and method gaps which would satisfy the information needs of the rehabilitation system in the United States? (2) In what form could information developed in other countries be presented? (3) What are the key transmission points/target audiences for sharing knowledge in the U.S. rehabilitation community? (4) What foreign resources can be identified to develop and share the information? (5) How can one evaluate the effectiveness of the program? (6) What steps could be taken to build on utilization of the materials?

The International Exchange of Information in Rehabilitation project is designed to facilitate the sharing of rehabilitation information transnationally by commissioning a series of brief monographs by foreign experts on topics which reflect knowledge gaps in rehabilitation in the United States. The design for the project emerged as the result of determining that a need existed for information to be made available transnationally to targeted groups of U.S. rehabilitation personnel at a length which would make information accessible and readable while at the same time satisfying curiosity about the particular subject.

In May 1 978 a Transnational Conference was held by World Rehabilitation Fund to which four foreign rehabilitation experts (generalists) and eight U.S. "centers of influence" in rehabilitation were invited, including representatives from the State Vocational Rehabilitation system, the American Coalition of Citizens With Disabilities, a Research and Training Center, the National Rehabilitation Association, Rehabilitation Counselor Education, and the Rehabilitation Services Administration (now the National Institute of Handicapped Research), as well as the World Rehabilitation Fund's Officers and Consultants.

The primary goals (as they related to the International Exchange of Information) of this meeting of the Advisory Council were to:

1. Decide on the knowledge gaps in rehabilitation in the U.S. to which this project would be responsive.
2. Obtain nominations from the foreign advisors present for potential monograph authors (individuals from their countries who could expertly address the topics).
3. Determine the target audiences for the monographs.
4. Develop the evaluation component of the program.

Final selection of five monograph authors for the Project Year '78-79 was made by World Rehabilitation Fund staff and consultants and these authors were then commissioned to prepare monographs over a six to eight month period of time. An initial first draft was submitted for U.S. and foreign peer review. The resulting reviews were then returned to the author who had the opportunity to make use of any comments, suggestions or criticisms in the preparation of the final draft.

Also, where utilization conferences were held (the project design called for the holding of conferences to promote research utilization and knowledge transfer on three of the five monographs), authors made use of feedback from conference participants to make final alterations in their material,

In some cases, the individual monograph will stand alone on its merits. In other cases, we are including United States commentary relating to the monograph itself and to the particular topic. This commentary emerges out of the peer review and participation research utilization conferences.

The World Rehabilitation Fund, Inc. is indeed pleased to be able to present this Monograph Series to the United States rehabilitation community with the hope that the monographs will help to promote the continuing exchange of information trans-nationally toward the ultimate goal of enhancing the quality of life for the disabled in the United States and all over the world.

It must be said that the World Rehabilitation Fund, Inc. took the philosophical position of allowing complete freedom in the preparation of these monographs. Therefore, the views expressed (and the knowledge and information conveyed) are those of the author, the sources the author has selected, and the national socio-economic context from which the material emerges.

Howard A. Rusk, President
World Rehabilitation Fund, Inc.

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We would like to be able to acknowledge *all* of those individuals who have shown an interest in the preparation of this monograph. However, there are indeed too many to mention here. We wish to thank particularly those individuals who shared their expertise at a research utilization conference held around this paper in its unpublished form, those who volunteered helpful peer review and those who have written commentaries to accompany *Attitudes and Disabled People: Issues for Discussion* in its published form: Tamara Dembo, Susan Daniels, Nancy Kerr, Lee Meyerson, Jerome Siller, Joseph Stubbins and Beatrice Wright. (For a list of all conference participants whose involvement with the monographs we are deeply grateful for, see Appendix A.)

Finally, we wish to express our appreciation to Mr. George Engstrom, NIHR project officer, for his help and guidance throughout.

SUMMARY

The central thesis of this monograph is that "disability" is an oppressive social relationship. Its focus is attitudes towards "disability". Prevalent attitudes, however, are only uncovered as a result of research or social analysis. It is argued that those who carry out research or social analysis of necessity participate in the "disabling social relationship". What we know about attitudes, therefore, cannot be separated from the conditions in which they are uncovered. The monograph aims to encourage service deliverers to adopt a more critical attitude towards their own participation in the disability relationship. It also seeks to encourage a more critical attitude towards views which treat the subject matter in isolation from the definite historical social relationship in which such attitudes are uncovered.

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1. INTRODUCTION

1.1 THE PARADOX OF DISABILITY

Since the turn of this century the number of workers, professional and lay, in industrial societies who work in the field of disability has increased enormously. Almost every aspect of the life of a person who is disabled has its counterpart in a “profession” or voluntary organisation. Potential and real control over the life of a disabled individual is a modern fact. This has resulted in the attitude that the disabled individual is obviously particularly dependent upon others for help. The growth of professional “expertise” in the field has also meant that these helpers have had an almost absolute monopoly in defining and articulating the problems of disability to the public at large. One result of this has been the appearance of disabled people as passive, the *objects* of research and help. The numerical increase in helpers has also necessitated the need for a team approach to the disabled individual. While the helpers have *grouped* together, gaining confidence in their roles from their colleagues, they have done so to help the disabled *individual*. Disability, therefore, has been seen as a personal misfortune.

The increasing help has also facilitated greater numbers of disabled people functioning independently in the community. Disabled spokesmen and spokeswoman have become increasingly active in articulating their own perceptions of their situation. Since the Second World War there has been a rapid growth in the numbers and size of organisations of disabled people and increasingly, particularly during the past decade, a growing group identity.

The most immediate impression of disability, therefore, is paradoxical. On the one hand there is the appearance that disability implies a personal tragedy, passivity and dependency. On the other hand disability can be seen as a form of group discrimination, involving constant struggles and independent action. The paradox of disability confounds any attempt to discover uniform attitudes towards disabled people. It is also a challenge to helpers to face squarely their role in a conflictual social relationship.

“Disability”, it should be noted, is given a particular definition in this work and much of the discussion is concerned with its real nature. It is defined in terms of the special form of discrimination, or social oppression, that is faced by people who are in some way physically impaired. In a sense, the whole monograph can be viewed as defining disability and as attempting to raise some of the issues involved in changing attitudes towards this paradox, called disability.

The monograph is addressed principally to those workers entering, or already working in, the rehabilitation and welfare services (whether professional, lay, full-time, part-time, disabled or non-disabled workers). It is also hoped that the monograph will be of interest to the “consumers” of help, disabled people, as well as their friends and relatives.

1.2 THE OBJECTIVES

The monograph makes no attempt to review the literature on the findings of attitudinal research in “the field of disability”. Nor is there any attempt at analysing the reliability and validity of the diverse methodologies employed both in researching and effecting changes in attitudes towards disabled people.

Two objectives are set.

- a) The monograph should lead to a more critical stance towards the situation and methods used in establishing what attitudes towards disability are prevalent in society.
- b) The monograph itself should make some contribution regarding modifying attitudes toward disabled people and the situations they face.

2. DISABILITY: UNDERSTANDING A PARADOX

2.1 DEFINING THE PARADOX

The increasing number of workers catering to the needs of disabled people has been paralleled by increasing State intervention in the provision of medical and welfare services. From its inception, the National Health Service in Great Britain has been involved in the provision of certain services, aids and equipment free of charge to disabled patients. The medical profession retained a large responsibility for the provision of these services and each individual prescribing doctor based his decision upon his accumulated “clinical experience”.

The Social Services’ involvement in the provision of services, aids and equipment to disabled clients, however, posed somewhat different problems for the personnel involved in decision-making. Firstly, the Social Services are engaged in providing services (e.g. “meals on wheels” to elderly or disabled citizens living in the community), aids (e.g. a bath seat) and equipment or adaptations (e.g. building a ramp in place of stairs), which have few traditions to draw upon. This ruled out the clinical tradition of the medical profession. Secondly, they have been concerned with the determination of eligibility for financial benefits and for administering these funds. In Great Britain it became of paramount importance to establish clearer definitions so as to determine who was entitled to services and certain benefits or provisions.

Following the proliferation of research and papers on suitable definitions, one set of definitions has received some currency in Great Britain:

Impairment has been defined as “lacking part or all of a limb, or having a defective limb, organ or mechanism of the body”. Handicap is “the disadvantage or restriction of activity caused by disability”. (1)

and the following is offered as an example of how these terms may be used:

A man had a leg amputated. Therefore he is impaired, and since he would have a reduction of his locomotive ability, he is disabled. If, however, he has a satisfactory prosthesis, a sedentary job, a car adjusted to hand controls and leisure activities which are not too active, he might well not be restricted in activity and therefore not handicapped. (1)

If we are to understand the significance of certain attitudes, we must be precise about to which aspects of disability they refer. We need to remember, too, that all we know about social attitudes comes from research in which researchers themselves form part of the paradox. Those involved in helping disabled people will not be able to evaluate the significance of what they are taught unless they are equipped to respond to the conditions under which these attitudes come to light.

At this point it will be helpful to look at an example of the way in which we define disability, or handicap, affects our interpretation of so-called attitudes towards disabled people. In their paper Kleck, et al (2) describe two complementary experiments. These involved a confederate of the experimenter engaged in a deliberate deception which entailed the enactment of “handicapped” or “non-handicapped” roles in an interviewing situation with the duped subjects. The confederate pretended to be a person with a leg amputation (sitting in a specially designed wheelchair) and interviewed subjects on a defined topic. The same confederate also interviewed subjects as a (normal) non-handicapped interviewer.

The details of the experiments and results are not of interest here. We are only concerned with the situation that was manufactured.

What is clear, if one accepts the definitions of impairment, disability and handicap presented earlier, is that the confederate is *not* “handicapped” in *either* role. Since a handicapping situation did not exist in the two described experiments (i.e. having a leg amputation impairment does not in itself relate to a disability which might cause the person to be handicapped as an interviewer), the findings cannot have relevance for handicapped people, although they may be revealing in relation to disability or, particularly, impairment.

It could be argued that the authors of the research used the term “handicap” in the sense of “impairment” or “disability” in the earlier quoted definitions. In fact, however, in their introduction they refer to the reactions a disabled or handicapped person (used rather interchangeably) may experience when meeting others as follows:

In the first place, the felt strangeness that characterises the initial phases of an interaction may be accentuated when one of the interactants is physically *disabled*. This notion is supported by the evidence that the non-handicapped person often reports that he is uncomfortable and uncertain when inter-acting with a *handicapped* other. (My emphasis, (2), p 425)

The point is that in the above research situation there is little reason to believe the findings would be less relevant had they confronted their subjects with any unexpected interviewer, from a mechanical robot to a cleverly faked lump of jelly. The researchers focus their attention on disabled people and interpret all their results from this point of view. If, however, disability is a paradox then we should also be concerned with the helper’s, service provider’s or, in the above example, researcher’s role in the disability relationship under study. In this case the researcher’s manipulation has so contrived the disability situation that, using the earlier definitions, the confederate in the role of a “handicapped” interviewer is not handicapped *but* the subject as interviewee is “handicapped”! This is so because under the research conditions of deception, where both the experimenter and confederate have information which they have deliberately kept from the subject, the interviewee is placed at a distinct disadvantage in his normal activity of making sense of his immediate world.

The need for clearer definition of the disability situation has, of course, not only arisen in relation to Social Service provision in Great Britain. It must surely be of significance that during the past decade the same need can be found in different countries for slightly different situations. A paper, for example, on employer attitudes towards hiring persons with disabilities offers:

As generally used throughout this paper, *impairment* refers to a physical, mental or sensory loss resulting from a bodily disorder or *pathology*. When the person with an impairment interacts with the environment, a *disability* may occur in the form of an inability to perform a given role or task, e.g. employment. Such a disability may stem from either the *functional limitations*, that is reduced bodily activity resulting from the impairment, or from social limitations, brought about by the restrictive attitudes of others. (Emphasis in the original (3), p 1 5)

“Handicap” is not referred to in this definition. The term “disability” however, is used in almost exactly the same way as “handicap” in the earlier quoted definitions.

Whether one sees attitudes as being associated with something in the individual (the impairment) or with the social situation has a profound influence on how one interprets the results of research. It is quite legitimate, for example, using the above definitions of impairment and disability to conclude that Kleck, et al’s subject interviewees were not telling us anything about the underlying attitudes towards a specific impairment (leg amputation), or about attitudes to handicapped interviewers, but something about an oppressive and disabling social situation (i.e. the research situation).

2.2 ATTITUDES CAN ONLY BE UNCOVERED BY PARTICIPATING IN THE DISABILITY PARADOX

If disability is viewed as a paradoxical situation involving the state of the individual (his or her impairment) and the state of society (the social restrictions which are imposed on an individual) then attitudes may be directed towards either, or both, of these aspects. Attitudes may be held towards the individual who is impaired, or towards the social barriers.

Attitudes, however, do not occur in abstract. People hold attitudes. People stand in definite relationships to the disabled individual (i.e. the situation involving the helper and helped where the latter is the disabled person). Thus the doctor concerned with pathology and impairment formulates his attitudes towards disability with this kind of focus in mind. The principal context for the generation of attitudes in the doctor’s mind is medical practice which legitimises one person “treating” another’s body.

Similarly, attitudes towards disability can only be known as the result of researchers working within a framework that has already made legitimate the relationship between a researcher on disability and disabled people. What I am suggesting here is that in all these situations where “others” are involved in doing things for or to disabled people, they are not in fact independent of the particular aspect of disability they are handling (treating, researching, helping, etc.). They are participants in the total disability paradox. Precisely because it is in the nature of disability (and, whatever the definition, this seems always to be implied) that there should be a disabled person and helpers, researchers, doctors, etc., people who come into these categories are firmly cemented to their clients in a totality which should always be seen as a whole.

From this point of view all the participants in the disability relationship may be viewed as legitimate targets for disability related attitudes. I have already suggested, for example, in the Kleck, et al, paper (2) that the interviewee is disabled (handicapped in the terms of the research paper), whereas the interviewer faking an impairment is not disabled. If we focus on the behaviour of the confederate interviewer we see very strange behaviour. The confederate behaves in a very stultified, rigid manner, asking predetermined questions in a set order and positioning himself in a set manner in the interviewing room, and so on. Clearly this person is not in control of his behaviour and acts like an automaton. From this one may infer very strange “disability” attitudes among researchers! Speculating about the “disability” attitude of the experimenter is left to the reader.

All those working in the field of disability and earning their livelihood from this occupation are dependent upon the existence of a never-ending disabled client

market. They are part of the disability complex. The contention, here, is that the experience of the helper side of the disability relationship makes possible the generation of specific attitudes towards “disability”. One particular characteristic of these attitudes is that, since they emerge from the “helper” (or able-bodied) side of the relationship, they focus exclusively on the “helped” side. Because the “helpers” are the articulators of how disability should be described and presented to the public, these one-sided attitudes are taken as representative of the totality - of attitudes towards disability itself.

From the above it will be seen that I view one’s working experience as an important basis for the development of attitudes. At the same time the predominant attitudes towards disability have been defined by members of the “helper” side of the disability paradox. Their views are so pervasive that disabled people often absorb these uncritically and present them as their own. However, increasing numbers of disabled people have, with the assistance of the “helpers”, achieved independence of them and are articulating their own perceptions of their side of the relationship. The effect of this has been to highlight contrary perceptions of disability and increasingly expose the underlying paradox.

The predominant focus of attitudes, help, research and so on has, as a natural expression of one side of the disability relationship, been *towards* the disabled person. Nearly all references concerned with attitudes towards disability, use the disabled person as the point of focus. The emergent approach is to focus on the behaviour, roles, perceptions, attitudes, etc. of the “helpers” as representatives of a socially determined disability relationship. From this vantage point the problem of influencing changes in attitudes can be seen in terms of altering the focus of attitudes on to the social relationship (and society as a whole). It may be impossible to uncover and influence attitudes without personally entering the disability paradox, but this paradox can be approached in profoundly different ways.

2.3 CREATING AND ELIMINATING DISABILITY

This is not the place for a historical analysis of disability. Nevertheless, it is necessary to say something about the context in which attitudes are formed. This will help establish the historical continuity of the views contained in this monograph which, at the same time, makes a break with the past.

Phase 1

Firstly, since the beginning of the modern era, although people with physical impairments have always been present as “cripples”, they were not segregated from society for special treatments and services which we recognise today. At the lower end of the economic ladder “cripples”, low-paid workers, the out-of-work and the mentally ill formed a broad oppressed layer of society in which there was a heavy overlap of roles. In London for example, in 1894 there existed a “Society for the Suppression of Mendacity”. It boasted a “Beggars’ Museum” which a reporter visited and recorded:

“It consists”, said my guide, “of a large number of the instruments and tools which have been used in past years by beggar impostors in the pursuit of their profession. How many beggars there must be in London I cannot imagine, but during the year our Society apprehends something like a thousand who are largely found to be impostors. You can understand the

great amount of work which we have done when I tell you that the Society has been in existence seventy-five years.” (4)

What is of interest here is the way in which able-bodied people could relatively freely (notwithstanding the efforts of the “Society”) enter the ranks of the crippled and that people could make a “profession” of this. The presence of people with physical impairments freely within the community facilitated this. Also of interest was the fact that although the “Society” had been in existence for 75 years no real impact in differentiating cripples from faking able-bodied beggars had been achieved. The “Society’s” attempts to weed out people with genuine impairments from impostors marks an early attempt to isolate cripples into a special class. (Incidentally, it is an interesting exercise to speculate how the “Society” would have regarded the impostor confederate, in the Kleck, et al, research, who in many respects had a professional interest in impersonating an amputee. They might have had even stronger views about the person who organised the whole set-up and who was, one assumes, earning his living from the exercise).

Crippled people, then, clustered at the bottom end of the social scale together with other social strata. Within the framework of the existing society no real alternatives for their total wellbeing had yet emerged and we can expect the dominant attitudes would have as their focus the individual. Attributing the personal blame for their social plight is likely to have been the characteristic way of holding attitudes towards cripples at that time - e.g. they were cripples because of their sins, wanton behaviour, etc., or because of the sins of their fathers.

Those who sought to segregate physically impaired people from their class origins, such as the “Society”, however, may well have started to differentiate their attitudes. They may have seen the poverty of cripples as the result of personal misfortune, whereas the poverty of able-bodied beggars was the result of indolence. The lack of success of the “Society” suggests that other forces must have come into operation before cripples (the social relationship of physically impaired people during phase one) could be transformed into disabled people (the social relationship of physically impaired people during phase two).

Phase 2

The second historical phase, I suggest, was generated by the creation of a new productive technology - large scale industry with production-lines geared to able-bodied norms. Phase two was inaugurated with the growth of hospital-based medicine and the creation of large asylums. Institutions must have provided the physical means for segregating disabled people from their communities. Here, the characteristic attitude must have been to view disabled people as suffering personal tragedies, being unable to care for themselves and consequently in need of care and protection. In phase one physically impaired people as cripples were socially active (entering for example the “profession” of begging), asserting their right to live and be in the community and being seen as responsible for their actions. However, phase two is characterised by attitudes towards physically impaired people which see them as passive, needing others to do things for and to them; as disabled! That many disabled people come to view themselves in this manner even today is a reflection of the pervasive success of the “institutional phase” in the history of disability.

While custodial institutions (such as asylums and alms houses) facilitate the segregation of disabled people, one consequence of having large treatment

institutions such as hospitals, is that they facilitate the development of organised skilled workers (i.e. professionals). Thus the hospital environment facilitated the development of nurses, physiotherapists, occupational therapists, social workers (almoners), counsellors, etc., and the alms houses, asylums, charitable homes ensured the success of the move towards segregation. The development of successful medical practices in hospitals ensured greater numbers of people with physical impairments surviving and must have strengthened the connection between disabled people and institutions as well as facilitating the medical dominance in the field.

Workers already *in situ* in the hospitals were sucked into servicing disabled patients and in time these “para-medical” workers spilled over into the custodial institutions. The growth of professions, particularly in the past two decades, has been phenomenal. Today there is almost no aspect of life for which there is no profession. At the same time the success of professional medical and “para-medical” help has contributed to the increasing numbers of disabled people able to achieve social independence and thus question professional “dominance” of their lives. The move towards increasing independence in the community marks the beginnings of phase three. The most important stimulation for this development, however, has been the new electronic technology for automating the production-line. This technology enables the most severely physically impaired people to operate environmental controls which can enable them to live relatively independently in the community.

Phase 3

The third phase can be viewed as just beginning, setting the context for the generation of new attitudes. In phase two the focus of attention is firmly on the physically impaired individual. In phase three the focus is the nature of society which disables physically impaired people.

The emergence of phase three suggests that new forms for the relationship between helper and helped will also emerge. If people with physical impairments are seen as having a long history of oppressive social relationships, then during phase one people with physical impairments were oppressed as “cripples”, and were an integral part of the lower strata of society. Such societies do not have the wealth and physical means to overcome the material conditions of cripples. During phase two, however, industrialised societies are transformed so that the means of overcoming physical adversity is increasingly possible. The segregation and discrimination suffered by disabled people can be seen as the form that oppression takes for physically impaired people in this phase. Phase three marks the beginning of a struggle to reintegrate people with physical impairments. From this perspective, in industrialised societies, phase two can be seen as the period in which cripples disappeared and disability was created. Phase three heralds the elimination of disability.

3. THE MISFORTUNE OF ADJUSTMENT

Disability, I have argued, is a social relationship. It is not the purpose of this monograph to examine the fundamental nature of this relationship. This must lie in a study of the specific way in which society places people with physical impairments in a definite relationship to the way in which the material conditions of life are created and recreated. The precise way in which they are relatively excluded from this process will determine their dependency upon others for the material conditions of life and hence their final status within the structure of society.

To those interacting with disabled people, however, the first impression must be within the context of their specific social roles. Thus the historical origin of the disablement of people with physical impairments is taken as given - disability is experienced primarily in the sphere of social relationships between people in which disabled people are already dependent and segregated. This is the predominant context in which phase two attitudes are expressed and sanctioned. There are three basic points of view:

- a) From the point of the helpers. The focus is on disabled people or on how others focus on them.
- b) From the point of view of disabled people. The focus is on others or the environment which they experience in their roles as disabled people.
- c) From the point of view of society as a whole where a) and b) are seen as two sides of a coin. The central focus is the helper/helped relationship. Whereas a) and b) reflect the perceptions of different sides of the paradox, c) focuses on the paradox. Disability is here seen as a special class of social relations involving people with physical impairments.

How one chooses to focus on disability must be related to how one experiences the *problems* contained within the paradox.

3.1 THE PROBLEM

When Wilson, et al (5) sought material for promoting rehabilitation programmes they thought "it is important to know how experts, future experts, and the intellectual elite view major disabilities" (5). They, therefore, took the standpoint of the helpers and the focus as disabled people. To "ascertain the attitudes" of these three groups they "were asked to rank eight major disabilities in the order in which they felt such disabilities might be disturbing to them personally if they were so afflicted" (5). The disabilities mentioned range from "Deafness (complete; not helped by hearing aid)", through "Blindness (complete)", to "Amputated leg (above knee)". What is quite clear from this study is that they see the problem is related to uncovering attitudes directed towards disabled people.

The phase two central tendency is to focus on the helped side of the disability relationship. This has been nicely brought to light in the Wilson research. They tried to uncover attitudes by asking "experts" to focus on imaginary disabled people (themselves). These "experts", we must conclude, did not question the assumed appropriateness of this focus for attitudes towards disability.

The same tendency is equally common in theoretical papers which look to conceptual and research issues. Burk (6), for example, when calling for more efficient rehabilitation services saw the "greatest dilemma" as

“(1) Of our total population, towards whom must our efforts be directed (i.e. Who are the disabled)? (2) Is disability a distinguishable entity (i.e. Can all its manifestations be defined in a universally accepted manner)?”

The first of Burk’s dilemmas obviously focuses on the helped side of the disability paradox. The second acknowledges that the problem area may be more than that merely defined by a focus on the individual. However, when discussing the broader concept of disability he concludes that it “would seem that there is increasing unanimity toward the attitude that severe, prolonged, incapacitating, crippling or painful illness often results in changes in the way the human being handles himself in his life situation.” It is clear that Burk’s broader concept retains the focus of attention on the disabled individual as having the problem. Only the backdrop of this focus shifts (from the hospital/rehabilitation unit?) to the mainstream social setting. There is no real shift in focus, merely a shift in context.

The consequence of this is that Burk, detecting the conflictual paradox in disability, concludes that this resides in the helper side of the disability relationship. It is professional infighting that leads to conflict so that “everybody’s business is nobody’s business”. Consequently, the proliferation of helpers find it difficult to help. Seeing the problem in this way inevitably leads Burk’s arguments astray precisely because the focus of attention (the helped) has not been questioned. Burk’s paradox involves “interprofessional and interpersonal jealousies”, which he says “can only be eliminated by the establishment and retention of the *proper* focus of rehabilitation; namely the needs of the individuals being served”. (My emphasis (6), p 13). Such a “*proper*” focus, albeit for rehabilitation, however, cannot lead to a different focus on disability.

Dembo (7) has shown great sensitivity in identifying the sides in the disability paradox. She has also recognised the importance of clarifying the “problem” and the paradoxical way the two sides (helper/helped) interpret this. Dembo sees disabled people as personally suffering the problems which have to be overcome. Helpers, on the other hand, she sees as distanced from the problem, acting as a scientist and viewing the “problem” in a detached way as worthy of investigation. She thus interprets the polarisation of sufferers and investigators on the basis of the helpers’ own beliefs about science and their own roles. In doing this she takes as given the phase two myths propagated by the *helpers* that they are “objectively distanced” from the objects of their work. A social perspective (Dembo’s “superordinate” vantage point?), however, indicates that the helpers/helped are inextricably bound together. The helpers’ belief in their scientific objectivity is a passive reflection of the phase two relationship which drives them into holding this type of attitude towards their clients.

It is inevitable that helpers, having their sights on human beings as their object of concern, should develop particular attitudes. These attitudes are the product of their experience of the “problem. In this respect the “objectivity” is not scientific objectivity but is determined by the total disability relationship. It is this relationship that defines the paradoxes - if one side is to have the helpers and the other the helped, then one side is to be involved and the other detached; one side to experience the suffering and the other to observe it; one side to comprise of independently active beings and the other to contain the dependent passive clients; one set to be stigmatised, the other without social blemish, and so on. Far from being detached from the “live problems” of disabled people the creation of rehabilitation professionals has its

origins in the genesis of “disability”. This sets the constraints for their approach to the complimentary side of the disability paradox, the helped.

Dembo recognises that the two sides of the relationship have different interpretations of “the problem”. However, she still appears to view the “problem” as *resulting from* the existence of physically impaired people. In her view there is an observer and a sufferer. While the former observes the suffering of the latter, the latter observes his or her own suffering - experiences it. Her one example refers to *suffering* pain, making the site clearly within the individual. Her other reference is to the disabled person who “needs help” and is consistent with the focus of attention on the individual situation. Dembo fails to clarify two crucial points: *why* is the disabled person suffering and exactly *what* is being suffered?

Disabled people, however, may have attitudes towards external social forces, or environmental barriers, which they feel makes them suffer. For example, a person in a wheelchair certainly suffers when he or she cannot get a wheelchair through the doorway of a toilet. In this case, however, the focus is the architectural barrier and both the “observer” and “sufferer” may study *this* “problem” with *equal* scientific objectivity. Since the problem is architectural (and social inasmuch as it does not affect one individual but all wheelchair users) it can be studied, analysed and solved independently of the disabled individual. The observer need not set his sights on the sufferer, or even on the sufferer in performance, but, like the sufferer, on external barriers. From this perspective the existence of disabled people is caused by “the (social) problem”.

3.2 NORMATIVE ASSUMPTIONS

The existence of helpers implies a number of problems have already been involved. Firstly, it implies a problem to be solved. Secondly, it implies that those who are helped *have* the problem. Thirdly, it implies the problem is within the individuals who are helped or legitimately part of the existence of those helped.

The typical phase two equation for the development of attitudes may be seen as something like this: If a disabled person has had an injury or disease resulting in an impairment, he or she has suffered a physical loss. The congenitally impaired baby confronts the expectations of the parents and it, too, is seen as having suffered a physical loss. Compared to other *individuals* the impaired person has suffered a misfortune, a personal tragedy. The problem now is to help the individual manage life with a loss - in effect to manage loss or misfortune. To do this, of course, the individual must firstly acknowledge the loss. The helpers’ tendency to assume loss in a disabled person, and their wish for client acknowledgement of this, relates to the helper’s role and the factors which legitimise that role.

If we imagine a person driving along a road reaching a junction and turning off to travel along another, we do not say he has lost something by following the new path. We only assume such a loss (e.g. lost his way) if we also assume or stipulate certain standards against which the deviation (turning off the road) is to be measured. The same applies to disabled people. The deviation from one modality of existence (e.g. seeing) to another (e.g. blindness) can only be called a loss, and therefore the person has problems, if the first modality is used as the standard for judgements about the second. Purely in terms of physical existence, which can be of infinite variation, any modality may be used as the standard. Hearing, for example, could be construed as the loss of peaceful silence.

The attitude that a disabled person has “suffered” a personal loss is a value judgement based upon an unspoken acceptance of the standard being able-bodied normalcy. But attributing loss to disabled people is not just the whim of certain helpers. The existence of helpers/helped builds into this relationship normative assumptions. “If they had not lost something they would not need help” goes the logic, “and since it is us, the representatives of society doing the help, it is this society which sets the norms for the problem solutions.”

The rise of normative assumptions, in phase two, represents a major change in the previous phase of social relationships involving people with physical impairments. One function of the helpers may be seen as to police or manage this transformation of physical impairment. Whereas in the first phase society recognised many forms of existence and maintained each reached their appropriate station (i.e. they were responsible for their poverty, problems, etc.), when this attitude was overturned it was replaced with the new view that all people should conform to a normal physical status. If this could not be achieved, because of the limits of medicine and technology, then the least that could be done was to approximate to this standard as closely as possible. The greater the approximation, the greater the participation in society. Those who *failed* would have no choice but would be regarded as deviants. Disability, then, always implies a failure to meet socially imposed able-bodied normative standards. Once “disability” is based upon a comparison with able-bodied standards, it follows that disabled people not only fail in achieving specific able-bodied skills, like dressing or reading, but that they cannot achieve complete equality as human beings.

The fact that adjustment to disability (or to loss) was not an issue during phase one of disability, whereas it is now, serves to underline that these attitudes are the product of changes in society and are not in any way intrinsic to the problems faced by people with physical impairments. The view that “Adjustment to misfortune” (8) is a problem for rehabilitation is itself the true product of the creation of “disability”. This pressure on adjustment amounts to no less than a pressure to absorb able-bodied attitudes. Absorption of these attitudes serves to motivate disabled people to conform to the norms of the society which created “disability”.

Discussing “misfortune” Dembo, et al, say that if a “painful event produces prolonged and more inclusive suffering if it affects a large part of the life space of the person, it is called ‘a misfortune’” (8, p 28). By an “event” they mean the establishment of a physical impairment. This is clear from the distinction they make between the “event” and the “circumstances surrounding the event”. For them the “social loss of the injured person - his feelings of non-acceptance as a group member - has a basis in reality.” Whether or not the person has adjusted to his loss, therefore, he will experience difficulties in his relationships with non-injured people. But the reaction in the two cases will be quite different” (8, p 63-64).

Once the disabled person has accepted his misfortune he will cease to think that his difficulties with others are the result of his own injury. The disabled person will see that the locus of the difficulties is not in the injured who adjusted to his personal loss, not in the natural lawfulness of devaluation of the injured, but in the non-injured.” (8, p 64). To Dembo, et al, then, the difficulty lies in the non-injured and not in the structure of society. Phase two is taken as given and their sympathies for the plight of disabled people takes them no further than the other side of this given relationship.

3.3 PHASE 2 CHOICES

When helpers, whether they are disabled or non-disabled, take on board unconscious phase two assumptions, they are bound not only to set out to inculcate their clients with these standards, but also to examine public attitudes from this standpoint. The techniques used to uncover public attitudes present choices to the interviewees or testees which limit their focus to disabled people. Attitudes, then, are only uncovered which focus on disabled people or on the problems which *they are considered to have produced*.

The Attitudes Toward Disabled Persons Scale (ATDP), for example, states its focus in the title. With this limited focus it is hardly surprising that Siller, et al, (10) should find that “it appears that the assumption of unidimensionality in attitudes toward the disabled is inaccurate. Our own work in this area, utilising depth interviews, has led us to believe that attitudes toward the disabled are multidimensional, measurable, a function of type and severity of the disability, specific experiences with handicapped persons, and possibly certain individual personality determinants”. (10, p 839).

The limits placed upon testees in attitudinal questionnaires can be demonstrated in the Disability Factor Scales (DFS) by Siller (11). A quick glance shows that all 69 items refer to disabled people. The introduction says: “On the following pages you will find statements of ideas and attitudes about disabled people. There are many different opinions about this *subject*” (my emphasis). The focus then, is on disabled people as a whole and in this context *they*, and attitudes towards *them*, are inevitably turned into a “subject”. The questionnaire, and the whole context of the exercise, is far from neutral. It performs a social act by giving a class of human beings (people with physical impairments) a special meaning, a specific social position - they are the focus of attitudinal research. In taking up the questionnaire and putting pen to paper the person completing the questionnaire makes a contract, as it were, to follow certain rules. These rules regulate the range of possibilities that the person filling in the questionnaire can perceive for disabled people. The focus of the questionnaire on disabled people exactly echoes the status society has already assigned to disabled people. Phase two, I suggested, singled out disabled people for special attention, treatments and custodial care by removing them from their roots in the community (albeit the lower strata).

Questionnaires, and other research methods, which focus on disabled people express the essential characteristics of phase two. These techniques mirror the historical fact of this phase and, at the same time, act as agents of society in ensuring that these attitudes are legitimised. The paradoxical disability relationship constantly works to turn the helper’s best intentions into its opposite. Gathering information so as to change attitudes which hinder reintegration into the mainstream of social life entrenches the view of disabled people as passive recipients of others’ opinions. The more extensive the application of such techniques, the more people are being taught the rules of phase two, the more we can expect such attitudes to become current in society. The difficulty is not located in the helpers or the “non-injured” but in the society which creates the paradox of “disability”.

If people are to be offered non-phase two choices (i.e. choices which are not limited by able-bodied norms), and thus allow for the possibility of alternative attitudes, the focus of concern has to shift off disabled people. To change attitudes, in other words, we have to change the rules of the game. The problem has to be redefined. If the rules of the game (phase two) determine what attitudes are possible, then the

most thorough way to facilitate changes in attitude is to produce a new game with different rules. The struggle for phase three needs to be consciously determined.

In the new game, with its different focus, Siller's DFS (11) for example, might take statements like "I feel uneasy when I'm near someone missing an arm or a leg" and change this to: "I feel uneasy when a motor car breaks down"; "People with cancer are often angry at the world" could be changed to: "People whose washing machines break down often get angry about modern technology"; and "With today's drugs, epilepsy is not a serious condition" could be changed to "With today's modern kitchen equipment, preparing a meal need not be an arduous task". A scale on attitudes towards aids to daily living could be derived. A scale of this sort does not segregate disabled people from non-disabled people. It focuses on environmental control systems, which are of fundamental importance to physically impaired people. Other completely new scales can be expected to emerge which would not focus on disabled people but on social inventions and social relationships.

4. DISABLING ATTITUDES

If we interpret the attitudes uncovered by research as the product of the disability relationship of phase two then, I believe, we have a more meaningful context for interpreting the relationship between attitudes and behaviour.

4.1 ATTITUDES AND BEHAVIOUR

On the one hand, helpers may have as their goal the maximum independence for their disabled clients. On the other hand, the helpers' behaviour may serve to reinforce their clients dependency on their exclusive knowledge for the solution to the physical and social problems. This paradox makes it possible for there to be an inconsistency between attitudes and behaviour.

Given that phase two has established the "helpers" as the spokesmen and women of the interests of disabled people, and given that the helpers' position is paradoxical, it follows that people in the general community will also take a paradoxical stance. On the one hand the existence of so many people in so many disciplines and occupations helping disabled people enables attitudes of positive concern to be socially acceptable. On the other hand, the existence of so many professionals confirms the incompetence of disabled people and enables people to accept and expect disabled people to occupy inferior social roles and to be socially and mentally inferior. It is not my purpose here to discuss details of how the complex social forces at work in phase two (such as the implications of charity, state assistance, new technologies, etc.) may relate to attitude formation, but to suggest that the paradox of "disability" in phase two ensures that attitudes and actual behaviour may very easily part company.

It comes as no surprise, therefore, to note that research and reviews show "the relationship between attitudes and behaviour to be highly complex, and that attitudes are only partial determinants of behaviour, along with norms, habits, contexts and expectations" (12, p 68).

Nor is it surprising, as Siller concludes in his admirable review of studies dealing with attitudes: "To most persons disability has little salience. However, in their responses, frequent stereotypes emerge which support the position that the status of the disabled is low and negatively tinged" (13, p476). Elsewhere he concludes: 'To date, significant progress in changing attitudes toward the disabled has not been achieved" (12, p 74). To my mind this is explicable if we recognise that such negative attitudes, and the difficulty in changing them, are no accident but are related to their appropriateness in the social climate of phase two. What is now required, it seems to me, as phase three is ushered in, is that there is a great need to question, research, analyse and focus upon "disability" from a completely different standpoint. That standpoint defines "disability" not as an attribute of an individual but as an oppressive social relationship between people with physical impairments and society.

From this point of view we perhaps need to reconsider or reinterpret what has been said about attitudes in the research. I see, for example, the work of Wright (14) and Dembo, et al (18) in this light. Their concepts of "misfortune", "suffering", "loss", "mourning" and "adjustment" raise the central issues I have been developing in this monograph. Can we agree with interpretations which imply mourning the loss of a physical attribute can help in the adjustment to social oppression? Is an oppressive

social relationship a misfortune requiring adjustment? Can we regard it a misfortune that people do adjust to disability?

Social oppression is, of course, felt as suffering but when people are placed in a situation where all the focus is on themselves it is almost impossible for them to recognise the social origins of their “disability”. Such attitudes are proscribed by phase two. Only a radical change can prepare the ground for different interpretations. Siller points us in the right direction: “By rotating the axis and attacking the environmental forces that turn medical conditions of disability into psychosocial conditions of handicaps, radical changes in the situation of the disabled can result” (13, p 458). I suggest, however, that not only radical changes in the situation of disabled people will result, but, to follow the logic of Siller’s statement, radical changes towards attitudes and attitudinal research can also result.

4.2 SIMULATED DISABILITY AND ATTITUDINAL RESEARCH

It may seem obvious that the way to change negative attitudes towards disabled people is by writing about the subject. One could draw attention to the fact that they are human beings worthy of “accepting” attitudes, that “despite” disability many make a positive contribution to society, that any able-bodied person might become disabled and the target of negative attitudes, and so on. However, as Siller has pointed out: “Providing information to selected groups in itself seems quite futile” (12, p 74).

There appears to be a similar futile process in attempts to effect attitude changes by means of “contact interventions”. Here, as Siller notes, the process is perhaps a little more complicated. The attitudes of the disabled people involved in the contacts can make an important difference: “Contact interventions may run the hazard of strengthening and reinforcing negative attitudes rather than fostering more positive ones. The quality rather than just the quantity of such contacts must be carefully controlled (12, p74). In my view one way of affecting the quality is by controlling the site of focus of attention. If it remains on the disabled person I believe negative attitudes are greatly facilitated. If the focus is on the environment, social relationships, particular activities, or any external situation or problem, then I believe positive attitudes may be increasingly facilitated. Disabled people may, of course, have absorbed phase two attitudes completely and will thus present themselves as the focus of attention and concern. Since little attention has as yet been paid to the focus of attention in contact interventions, research in this area can be viewed as indecisive.

Similarly, the actual situation in which contact is made may influence the focus of attention. A visit to an institution, as an experiment in modifying attitudes has been described by Cleland and Chambers (15). They say:

“The evidence presented is generally supportive of the hypothesis that significant shifts in attitudes are induced by a ‘guided tour’ of the institution, but that these attitude shifts are not necessarily of a positive nature”.

In my view, the total situation resulted in a very sharp focus on disabled people. This was bound to have a strong effect on legitimising the view that the problem resides within, or is, disabled people. Of course, some members of a touring party may react to the institution and alter their attitudes about the appropriateness of such places. But this, in itself, is unlikely to lead to a shift in focus. It is also

theoretically possible for some to react to the whole visit, its intentions and its focus for the problem. They may spontaneously seek alternative frames of reference for understanding the situation of disabled people. Such a reaction may lead to questioning of assumptions and the nature of the problem implied in the visit.

An extension of the idea of utilising contacts as a way of influencing attitudes, while still keeping the focus on disabled people, is to ask able-bodied people to play the “disabled” role. Clore and Jeffery (16) conducted a role playing experiment in which (a) role players were asked to travel about a university campus for about an hour in a wheelchair, (b) vicarious role players walked about 20 feet behind the role players observing the role players’ experiences, and (c) a control group walked about the campus for an equivalent length of time. Their conclusions are interesting:

“The results show that role playing a disabled person in a natural social environment has both immediate and long-term effects on interpersonal attitudes toward disabled students. Those who played the role of a disabled person by travelling around the campus in a wheelchair responded significantly more positively than control subjects. ... Subjects who experienced the role playing vicariously (by watching) displayed similar effects.” (16, p 110)

Concentrated focus on disabled people, in the form of role playing, can, paradoxically, lead to a shift in focus on to the social and material environment. I believe that role playing may facilitate changes in attitudes precisely because the participants can come to view the environment (human and physical) as hostile. They see this as disabling. This change in focus enables them to change their attitudes towards disabled people, who are no longer seen as having *the* problem.

The comments of the student subjects in Clore and Jeffery’s research are revealing:

“The looks that I received were very interesting and were consistently the same. People look out of the corner of their eyes and then a downward glance past my legs. They seem a bit embarrassed.” (16, p 110)

Clearly, the student’s attention was firmly fixed, not on himself as a disabled person, but on others. Another student comment reads:

“My arms started to bother me When I got to the ramp. ... I started to go up and realised I was never going to make it.” (17, p 110).

The question is, is his focus on his arms or on the ramp, and where is the problem? Can he legitimately see the problem residing in his arms, which are quite normal? If he does see his arms as his problem, what has transformed a perfectly normal set of arms into a problem? If, on the other hand, he takes himself as given (and why shouldn’t he since he is “normal”?) and focuses outwardly, to what can he possibly attribute his problem?

A number of questions may also be asked about the vicarious role players (who only watched the role player). They, too, changed attitudes in a positive direction. What exactly was being watched? Did they focus on the role players observing how effectively they played their parts? Did they observe the reactions of others towards the role player? Perhaps the instruction to the vicarious role players to “observe the role player’s experiences, doing everything he did” would facilitate observation of others’ reactions to the role player. This may have been more likely if they knew the person in a wheelchair was faking, but it is not clear whether being “informed about

the role being played by those in the wheelchair” also meant being informed that a role was being played (my emphasis) (17, p 106).

One way of trying to modify attitudes may be by contriving a change in focus from the disabled person to the social and material environment. For example, able-bodied subjects who are enthusiastic model aeroplane builders could be brought together with similarly inclined disabled people. The specific task could be to share the joint goal of building a model. Any physical problems the disabled person may have in contributing to the final goal, then, could be seen in terms of the final goal. These could be viewed as joint sub-goals to be solved - e.g. the difficulty in holding a cutting knife. The kind of contact situation suggested here differs from the phase two approach in that it looks at the generation of attitudes in situations where the disabled and non-disabled participants set out to perform the same social activity.

Changing attitudes in role playing situations may be regarded as one important step towards phase three approaches. What are needed, however, to ensure the momentum of phase three, are situations where it can be publicly recognised (as Siller says) “that it is the responsibility of the people most affected - the disabled themselves - to shape their relationships with the non-disabled so as to maximise successful interactions” (12, p 75). The social interactions of physically impaired people, however, I believe, do not have anything to do with coping with deviance, managing a strained interaction or dealing with stigma.

5 STIGMA: Spoiling the notes on the management of prejudice

To most disabled people the problem of prejudice is one of the central issues in any move towards mainstream social participation. Obfuscation of the attitudes involved in prejudice, therefore, is an important matter necessitating special attention and the reason for this section in the monograph. As physically impaired people increasingly move into the community mainstream we can expect that prejudiced people will seek out a special mark, or stigma, which will serve to keep them in their place - in the confines of phase two. Prejudiced people, of course, always attribute their attempts to devalue others as the “natural” result of negative qualities possessed by those they wish to devalue. During the past two decades the concept of “stigma” has come a long way in making “prejudice” socially acceptable and in enabling bigots to deny responsibility for their attitudes. Goffman has been one of the main authorities responsible for popular acceptance of the concept of “stigma”. He makes his view on the creation of stigma very clear. He takes his inspiration from the ancient Greeks and says they:

“originated the term to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier. The signs were cut or burned into the body and advertised that the bearer was a slave, a criminal, or a traitor - a blemished person, ritually polluted, to be avoided, especially in public places”. (17, p 21).

Firstly, slavery was not unusual in Greek society - in fact it was commonplace. Secondly, I don't think branding a slave had anything to do with exposing something “bad about the moral status of the signifier”. Placing a stigma upon a slave had the purely technical function of preventing them from escaping their oppressive relationship with those who so branded them. It was precisely because slaves were constantly rebelling and trying to escape their oppression that it was necessary to fix permanent signs to their bodies. Thirdly, it was in the nature of slavery that the owners (or their spokesmen) should assert that certain people were naturally and appropriately slaves. In this context it is inevitable that the oppressors will view slaves as morally bad, blemished, etc. It is quite superficial then to believe that stigma is affixed for this purpose. To subscribe to this view is to take the standpoint of the slave owners (and their spokesmen) rather than from an analysis of society as a whole or from the standpoint of the slaves.

Fourthly, the ownership of slaves was, to the upper classes, highly desirable. It is misleading to see stigma simply as indicating people who are to be avoided (even if this is confined to public places). What it indicates is the differentiation of people into two social groups and that this stratification of society is one-sided, an imposition of inferior status by the wealthy on the poor. The issue is, therefore, basically one of “segregation” and “oppression” and only in a secondary way, one of “avoidance”. It is quite clear the slave masters did *not* avoid their slaves; they had and used them for their most personal intimate and sexual needs. Fifthly, it is a distortion to view the person who has been forcibly branded so that he or she permanently carries a stigma as the “signifier” of a bad moral status. This is to invert the real social relationships whereby the one who assigns the stigma is the “signifier” and the one who is chained and forced to bear the oppressor's views of himself is the bearer. To say the bearer of suffering is the “signifier” of attributes assigned to him is to take the standpoint of the oppressor in the slave/master relationship.

From the above it will be clear that I feel Goffman has profoundly spoilt the identification of oppression in ancient Greek society. He has neutralised the role of “stigma” in the maintenance of an oppressive relationship between one strata of society and another. His view also obscures the function of stigma as a device for segregating people into a social class. Finally, the interpretation serves to shift the attention from those who create the problem on to those who begin to appear as the ones who signify it. To Goffman, Greek society is taken as given and the imposition of stigma is interpreted from the standpoint of the ruling strata as a device to identify the socially unusual. I, however, believe a conflict model is more appropriate. Only such a model can explain the function of stigma in maintaining the supremacy of slave owners in Greek society where there was a never-ending struggle by slaves, not just to eliminate stigma, but to eliminate their social status as slaves.

Having spoilt the identification of stigma in ancient Greek society, Goffman turns to the modern situation where he applies the term: “Today the term is widely used in something like the original literal sense, but it is applied more to the disgrace itself than to the bodily evidence of it” (17, p 11). He thus sees stigma, applied to physically impaired people, in non-oppressive terms. He takes as given the establishment of phase two with its imposed segregation, passivity and the inferior status of disabled people.

Once stigma is neutralised as the natural exercise of marking the “unusual”, then it can be seen as something possessed by disabled people. Since those attributing stigma to others are, from this viewpoint, not doing anything oppressive but at the same time they are reacting differently to disabled people then, it follows, disabled people are losing an opportunity for “normal” socialisation. From this point of view Goffman, of course, concludes:

“The central feature of the stigmatised individual's situation in life can now be stated. It is a question of what is often if vaguely, called ‘acceptance’.” (17, p 19)

Thus disabled people are permanently placed in the dependency role, of phase two, constantly seeking “acceptance” from those who stigmatise them (i.e. those who are responsible for their dependency in the first place).

It is of course nonsense, particularly at the time when they are increasingly breaking the dependency bounds of phase two, to conceive of disabled people as being dependent upon bigots and prejudiced people for “acceptance”, just as it would not make sense to consider freed slaves (still carrying their brand marks) as dependent on their former oppressors for “acceptance”. Nor do disabled people suffer any loss of social maturity because they are denied social intercourse with those who stigmatise them. The contrary would be true. Only by viewing the imposition of stigma as a natural act, unconnected with prejudice and oppression, is it possible for Goffman, and those who agree with his concept, to obscure the particular way in which phase two generates prejudice.

This cosmetic operation then makes identification of debilitating attitudes and those who hold them so much the more difficult to research, identify and change. It reinforces the phase two obsession with disabled people and their bodies. It places all the problems on the shoulders of this group who are encouraged to believe that they should take their “disability” as given. The attitudes and values of the disability

relationship, then, are seen as the determinants of *all* physically impaired people's social relationships. Thus, for example, Kleck can say:

"We have found evidence that physically stigmatised individuals *elicit* an avoidance response from physically normal persons" (18, p 58, my emphasis).

To say disabled people elicit avoidance responses in others is to remove all responsibility from able-bodied people for their attitudes. Goffman's concept of stigma mystifies the real nature of prejudice and enables bigots to escape responsibility for their own behaviour. It makes disabled people responsible for their own suffering. This makes as much sense as to say the slave elicits his master's abuse of him.

In closing this section I should mention that not everyone, of course, uses the term "stigma" in the same way or consistently. In very many cases "stigma" is used in the same sense as "prejudice". Scott has drawn attention to this problem and to the range of meanings given to "stigma". He says:

"What is not so apparent in the social science literature on stigma is that there are ... striking differences in the meanings of stigma that are found in experts' theories about them." (19, p 110).

6. PHYSICAL DISABILITY: A MATERIALIST APPROACH

The transition from phase two to phase three is already under way. Increasing numbers of disabled people have achieved reintegration and asserted their own interpretation of their situation. The central characteristic of attitudes held from this point of view is that they focus outwardly towards the social and material environment. This focus posits the problem in society and logically leads to a social definition of disability. One such definition has been proposed by the Union of the Physically Impaired Against Segregation:

“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. To understand this it is necessary to grasp the distinction between the physical impairment and social situation, called ‘disability’, of people with such impairments. Thus we define *impairment* as lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body; and *disability* as the disadvantage of restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. Physical disability is therefore a particular form of social oppression.” (20, p 14, my emphasis)

From this point of view, disability as a social relationship can be altered or changed. Once social barriers to the reintegration of people with physical impairments are removed the disability itself is eliminated. The requirements are for changes to society, material changes to the environment, changes in environmental control systems, changes in social roles, and changes in attitudes by people in the community as a whole. The focus is decisively shifted on to the source of the problem - the society in which disability is created.

6.1 REDEFINING DISABILITY

Redefining disability in the above manner involves turning attitudes upside down and re-examining all previously held assumptions. The view that disabled people suffer a misfortune is pervasive. A century of inculcating people with the attitude that says they cannot work, or use public transport, for example, because of their disabilities (meaning their bodily form) cannot be changed overnight. One way of illustrating that the environment, and the way it is altered by human beings, can disable or free human beings is to examine the human condition in space exploration. Given the environment on the moon, for example, man without special equipment would be totally disabled and unable to function. Given all the technological and human back-up support, however, the paradox emerges whereby the able-bodied human being becomes free to wander the moon but totally dependent upon technology and other human help. Any flaw in the technology, or mistake or restrictive practice by the human helpers can immediately disable the able-bodied moon walker. Clearly the cause of his disability in such a case would not reside within himself.

Another way of exploring the subtleties of disability is to pose a world where, say, everyone was in wheelchairs and where the material and social organisation of society was designed according to their needs. In such a world if the able-bodied could become disabled we would be illustrating that disability is the product of social forces and not physical impairment.

It is easy to imagine that in a community where everyone uses wheelchairs and determines their own social environment that the architecture would soon reflect the character of the residents. Door and ceiling heights, for example, could be lowered substantially. If now, able-bodied people were to live in this community they would soon find that they were prevented from “normal” social intercourse - they would be constantly knocking their heads against the door lintels! Apart from bruises the able-bodied would inevitably find themselves prevented from using the wheelchairuser-designed environment and aids. They would lack jobs and become impoverished - they would become disabled! (See 23 and 24 for further elaboration of this concept).

The implication of shifting the focus from disabled people and on to the material and social organisation opens completely new avenues for research. The first conscious example of this approach known to the author involved a study of the way housing can be designed so as effectively to disable people. The concept emerged of “housing disabilities”.

Firstly, Finlay, et al considered current theories of disability as the basis for their research. They examined Harris’ definition (1), quoted earlier in this monograph and concluded:

“The term ‘handicap’ as defined above (the Harris definition) seems to convey the impression of an interaction between people and their environment in which the performance capacity of the person rather than that of the environment is regarded as being in some way or other deficient. Such a definition is clearly of little use in the context of a research project which is intended to investigate ways in which the particular needs of those people prone to reduced performance capabilities in their homes can be alleviated, since it implies that the physical attributes of the average home should be regarded as constants against which para-medically defined variables, designed to describe individual’s functional capacity, would be measured. Taken to its logical extreme, such a definition of ‘handicap’, when applied to the policy formulation, would accommodate only those recommendations which could in some way improve the performance capacity of people rather than of their environment”. (21, p 13)

They, therefore, concluded that the prevailing conceptions of disability were of little help when trying to formulate a new approach which accepts the individual as the standard against which restrictive practices should be measured. Finlay, et al, say their:

“... research team has attempted to investigate the housing needs of people prone to reduced performance capabilities by taking their own physical attributes as given, and measuring against them the various physical attributes of their environment which restrict their ability to function to an extent that they themselves regard as unacceptable and yet believe to be avoidable. Thus the uniqueness of the interactions between the particular physical attributes of each of the people interviewed and his or her environment have been taken into account.” (21, p 15).

The shift in focus is decisive and represents a major change in attitude towards disability. It was hardly surprising, then, that the “research team concluded that none of the published questionnaires (used to uncover the problems experienced by

disabled people) was capable of producing information which could be analysed within the context of the (research team's) ... concept of housing disability (21, p 29).

The new questionnaire they designed was intended to uncover "the incidence, cause and extent of housing disability, based upon the need to adapt or build housing to suit the needs of disabled people and their families." With this focus, questions relating specifically to disabled people are only posed in the context of the main concern:

"... the only questions asked on the questionnaire that relate to impairment and handicap do so in way that provides information on the reduction or loss of the respondent's functional ability ..." (21, p 29).

The research, then, departs radically from all previous approaches institutionalized during phase two. The question can then be asked whether a social concept of disability has any practical implications for uncovering attitudes and for changing the situation of disabled people?

In Great Britain the Chronic Sick and Disabled Persons Act (1970) (CSDP), has been hailed, by some people, as a breakthrough in British legislation for disabled people. One of the requirements of the Act was for local Social Services authorities to acquire statistical information about disabled people living within their administrative boundaries. This has led to a large number of surveys being carried out - these are generically referred to as CSDP surveys. Discussing a Department of Health and Social Services (DHSS) study of surveys made by social services authorities in response to the CSDP Act, and comparing this study with the Finlay, et al, research project, a reviewer had this to say:

"It cannot be alleged that the DHSS findings are of no value. It is, however, difficult to draw from them any information of practical relevance, and looking at the two reports the impression is that the ... (Finlay, et al) study is worth more than all the CSDP surveys together." (22, p 26)

The phase three approach has taken root and we can increasingly expect to find research projects and material assistance to physically impaired people consciously shifting their focus to site "disability" in the infinite variations of social life, and not within disabled people.

It would also seem possible for research on attitudes to adopt the social definition of disability whereby "attitudes towards disability" refers to the material and social components of society which effectively disable people with physical impairments. Thus it should be possible to devise methods of researching attitudes and behaviour towards, say, "housing disabilities", or "travelling disabilities", or "communication disabilities", etc. The questions would entail, for example, an exploration of people's attitudes to housing without steps, or having alternative ramps and elevators. The same approach could be taken in exploring attitudes towards "talking books" (for all people as a parallel medium of information), where the printed word represents the particular "disability" under study, and so on.

6.2 DISABILITY AND HUMAN HISTORY

In phase two the focus on disabled people is so strong that those who would help lose sight of the fact that able-bodied people in *their* activities of daily living, in modern industrial societies, are equally dependent on help. *However; this*

dependency does not make them disabled. A simple example will be used to bring out the basic points - a person washing her hands:

In “normal” circumstances she would go into the bathroom, turn on the hot tap and, using soap, wash her hands. To the average “helper” in “disability” such an act shows the able-bodied person’s ability to carry out a normal daily activity without any assistance. But is this in *fact* so? Let us imagine the main water pipe to her house has burst. The immediate effect would be that she could no longer obtain water and so wash her hands. She is thoroughly dependent upon able-bodied aids to supply water. If she goes to a neighbour to borrow water she is seeking assistance from others and so reveals that she is not independent of social help. If she decided to be entirely independent and go to the river to get water she would have to abandon her bucket, for that is another able-bodied aid, refuse to use public transport and remove all her clothes, for all these are able-bodied aids made by other people or utilising the assistance of others. Now naked in front of the river (if she can find it in a modern city) she could wash if she has time before being arrested for exposing herself or trespassing private property. Even assuming she could finally wash her hands completely independently, she could hardly carry out this procedure as an activity of *daily* living and *still* participate normally in society. In fact, she would have gained her independence by abandoning the very essence of modern society in which she lives. Living independently of able-bodied aids, therefore, is incompatible with living in modern society.

The same state of dependency on other people can be revealed if we imagine that instead of water-pipe bursting, the administrators, planners, engineers or other workers were to strike, thus cutting off the water supply. In this case she would be seen to be dependent in a very fundamental way on the assistance of others. The fact is that modern living is totally dependent upon aids and human assistance.

Given that modern life paradoxically means that independence is achieved through greater dependence on others, the question, then is how does this differ from the requirements of disabled people? The fact that an able-bodied person requires a wash-basin, tap, plumbing and so on, as well as an army of people to plan, build and maintain the water works so that he or she can wash indicates that *dependency is not unique to disabled people*. Similarly, the use of aids and human assistance by able-bodied people is not construed as evidence of failure or an inability to carry out a task. It would be inconceivable to construe able-bodied people as suffering a misfortune because the nature of their bodies necessitates aeroplanes to fly. Nor is this dependency construed as evidence of disability. The dependency of all human beings should not be used as evidence that everyone is, somehow, disabled. This rather superficial interpretation of disability obscures the real way in which physically impaired people are disabled by society by being prevented from participating in the historical evolution of mankind.

The long historical process leading up to modern industrial societies has been able-bodied people finding suitable rivers to wash in, clearing the bank to reach the river comfortably, damming the river to create a plentiful supply of water, devising buckets to remove the water and tanks to store it in, placing the storage tanks away from the river nearer their homes, piping the water to the tanks, building wash-basins and taps, etc. In all of this able-bodied people have been extending their range of

activities and increasingly become dependent upon aids and others. In all of this able-bodied people have moulded the environment according to their self-perceived needs and in accordance with their physical make-up. The activity, washing hands, then, in our society should not be taken as given. People with physical impairments, however, have not influenced this creation of “hand washing” and consequently are prevented (disabled) from carrying it out, not by their personal characteristics but by the way hand washing” was created.

Disabled people, also, no less than able-bodied people, need to express their essential human nature by moulding the social and material environment and so influence the course of history. What stands in the way, (at a time when the material and technological basis for solving the human and material needs of disabled people have mostly been solved), is the dominance of phase two attitudes and relationships. Such attitudes take society and, indeed, the dependency relationship as given. There is an obsessive focus on the disabled person’s body. It is measured against “normative” standards and found, together with the person possessing it, wanting.

To free disabled people from the restrictive effect of phase two it is necessary, in my view, to free them from normative (able-bodied) physical standards and able-bodied activities. Such a change will enable them to see themselves as independent beings against which they measure the material and social environment’s capacity to satisfy their needs. To facilitate the emergence of phase three, then, it is necessary to adjust the focus of our attitudes. In other words, to help disabled people increasingly to participate in the mainstream of social intercourse it is necessary to mainstream attitudes and attitudinal research.

6.3 ATTITUDES: A FINAL WORD

It was the intention of this monograph not only to discuss central issues involved in understanding and affecting changes in attitude towards the problems disabled people face, but also to contribute to this process by influencing the attitudes of its readers. There is no way for the author to assess the achievement of such an aim. However, it is hoped that those who do find they are able to reconceptualise the problem as not residing within people, will find that they are freed from the fetters of phase two attitudes. Such freedom, I believe, can lead to infinite new possibilities where the problems faced by people with physical impairments are seen as a challenge requiring inspiration and innovation, excitement and daring and where the management of prejudice and adjustment of misfortune are attitudes of the past.

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U.S. Commentaries
on
“Attitudes and Disabled People:
Issues for Discussion”
by
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**COMMENTARY ON FINKELSTEIN'S, "CHANGING ATTITUDES
AND DISABLED PEOPLE: ISSUES FOR DISCUSSION."**

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Finkelstein has made a radical argument which if supportable has great implication for almost all of the writing and research in disability. In effect, if he is correct almost everyone active in work with the disabled, including myself, has been actually promoting a negative situation for the very persons for whom we intend to be a positive element. Objective consideration of such a serious charge naturally becomes most difficult under the circumstances.

Rather than responding with a counter-polemic, I would like to acknowledge that elements of his reasoning regarding the social conditioning of "the situation of the disabled" are very sound. However, I do not believe that if professionals were to cease to identify special populations as persons with disabilities or psychoses or mental deficiency that the situation for such persons would materially change for the better.

I will focus on a few of the many points that for me weaken the presentation of the important issue that a truth of the concept of disability is that it is not an attribute of an individual but an outcome of an oppressive social relationship between people with physical impairments and society. A concept which many of us, in our own ways, have had as the core of our work for many years.

I cannot entirely follow Finkelstein's distinction between handicap and disability from his brief description. However, even if this were clarified the crux of a set of problems in his paper is revealed. By restricting his focus to the physical limitations imposed by impairment, Finkelstein does not include within his model conditions such as scarring, burns, and other purely cosmetic physical conditions. Nor does he give full recognition to the important differences between visible and non-visible conditions. Further, there are *real* limitations with real consequences for social interaction. The interesting question, for me at any rate, is why those particular consequences? Some of us have devoted considerable attention to answering precisely that question.

By treating attitudes toward those with physical disabilities solely in terms of functional limitation, Finkelstein leaves himself open to what might be called a sociological-economic fallacy. That is to say that one attempts to account for the phenomena solely in terms of factors external to the particular person involved. The fact that a *physical* condition is involved introduces an important discontinuity with other stigmatised conditions so that while ethnocentrism, alienation, and other personality factors are predictive of reactions across stigmatised populations including the disabled, unique elements are introduced with the physical (e.g., Siller et al., 1967a).

Physical difference, even if not at the level of deformity (also a value judgement), evokes strong feelings entirely personal in nature which are not particularly tied into one's functional value. In short, I have no reason to believe that the situation described by Finkelstein *creates* the problem so much as it aggravates a pre-existing one induced by strong intervening factors such as reaction to cognitive dissonance,

narcissistic threat, castration anxieties, etc. Thus, in a recent doctoral dissertation completed under my direction (Fine, 1978) it was shown that negative reactions in pre-schoolers were almost universal and preceded correct identification as being "different". Castration anxiety was associated with early perception of "difference" and greater attribution of negative traits. Another student of mine found a significant relationship, with adults, between tolerance for pain and ego defence style with attitudes toward the disabled (Gladstone, 1977). A third student is specifically relating level of object relationship to attitudes (Follansbee, in progress). Social factors such as status and economic well-being likely are imposed upon these more personologically based ones.

My inclination is to view attitudes as social phenomena an important aspect of which is to handle affect aroused by factors such as described in the preceding paragraph (Siller, Theoretical Outline, unpublished). The researchers in defining stimuli such as "amputee" or "deaf people" or "people with impaired hearing" will influence the kind of response to a degree. The issue of labelling has received adequate attention and need not be repeated here. However, the researchers do not create the stereotype, they identify it, measure it, and provide a basis for combating it! It is inappropriate to use even as a far fetched example that hearing could be construed as the loss of peaceful silence and to imply that by calling something a deviation without attaching a valence rather than a loss that we really have improved things. Absence of hearing *is* a loss. It need not have the multitude of negative ascriptions attributed to it that it does but let us avoid a new version of the Emperor's New Clothes.

In discussing Phase 2 choices, Finkelstein raises the very relevant point that approaches which assume the stance of disabled persons as the objects create a methodology in line with this. To limit one's focus entirely to disabled persons in creating techniques could readily lead to inappropriate conclusions. My own work on the Disability Factor Scales was discussed in that light. Let me take the opportunity to (1) support Finkelstein on the importance of this point, and (2) to show that sound research procedures can avoid some of those problems. In fact, the actual work on the DFS in every instance considered and dealt with the problems raised by him. It is true that all 69 items of the DFS refer to disabled people as he notes. But it is also true that extensive work was done in the initial steps of the development of the DFS series of questionnaires to determine empirically the impact of having non-disabled items in the total item set. It was found that non-disabled items should be eliminated because they were distracting in the sense of mixing referents, and unnecessary for measurement purposes because they almost entirely were uncorrelated with disability items and factored out separately (Siller et. al, 1967b).

In performing "a social act by giving a class of human beings (people with physical impairments) a special meaning, a special social position" as "subjects" of attitudinal research one might object that what is being measured is what already exists. If we are imposing something that isn't pre-existent how could we get so readily highly reliable, experimentally useful measures of tremendous factorial invariance? In fact, Finkelstein himself commits the "sin" of calling people with physical impairments "a class of human beings." His approach requires the denial of "classes" because to talk of classes is an abstraction based on a particular characteristic and turns that group into "subjects." We would be left with only the completely idiographic were Finkelstein to be taken literally.

In that same paragraph it is said that the range of possibilities in which people filling out the questionnaire can perceive disabled people is limited. This is true. However, in the instance of the DFS an extraordinary range of possibilities was entertained and what appears is only the final distillation of extensive pilot work. One should always be receptive to new possibilities of course but to date no one has proposed anything that already is not represented in the scales. That we are “removing *them* (my italics) from their roots in the community” hardly seems to be the point when one is trying to tap pre-existent stereotypes.

Phase 2 techniques are indicted as legitimising in a paradoxical way the perception of the disabled recipients of others’ opinions. This is a subtle but important point. In practice we intend to use our materials to help disabuse those with negative attitudes. If this is subtly helping to reinforce passivity and dependency by stressing disability as something only in the disabled person then much needs to be done. I believe that while this probably is happening, it is unlikely that *a/* professional or scientific activities necessarily violate the growth, autonomy, and well being of others.

To play a new game based on so-called Phase 3 rules where social inventions and social relationships are stressed really is not a new game. In his rewriting of my items he would find, as we did when this was done in our pilot work, that disability items, as indicated above, separate out from non-disability ones. Procedurally, one easily tests for continuities of attitude by correlating disability stereotypes with such other variables as ego strength, dogmatism, liberalism, conservatism, aids to daily living, etc.

It is unfortunate that people tend to think in terms of stereotypes and to have prejudicial attitudes toward those who are different. It is also unfortunate that at different times in history that certain physical properties will attain particular negative valences. It is particularly unfortunate that although the specific physical feature may vary from epoch to epoch physical features always seem to be salient. A tour-de-force that eliminates the concept of disability still won’t undo the obvious. I once was told by a fine psychoanalysis who had severe residuals from polio about his own first session in psychoanalysis. At the end of the interview he was told, “And don’t forget. After all of this you are still going to be a cripple.”

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**COMMENTARY ON FINKELSTEIN'S, "CHANGING ATTITUDES
AND DISABLED PEOPLE: ISSUES FOR DISCUSSION."**

WHO IS RESPONSIBLE FOR DISABILITY?

NANCY KERR *

The monograph is thought provoking, stimulating and contains many good ideas. In fact it is a refreshing and needed swing of the pendulum that should help to shift our thinking from worrying about the "poor unfortunates to considering the ways in which society makes life difficult for people who have physical impairments. However, as a physically impaired person and also as a "professional helper," I feel that Mr. Finkelstein has gone overboard in blaming society for creating disability. Therefore, my comments are directed at trying to bring the pendulum a little closer to the centre.

Field Theory, which has had considerable impact on many people's thinking in rehabilitation, has long held that "problems" do not lie solely in the person or in the environment; they do lie in the interaction between the two. That interaction can be changed from a "problem" to a satisfactory situation by changes in the person and/or the environment. Such a theoretical framework leads to two value judgements: 1) People with "different" physiques do run into a variety of problems not encountered by the able-bodied; and 2) The responsibility for alleviating those problems must be shared by both the physically impaired and the society at large.

RESEARCH ON DISABILITY

With respect to the criticisms the monograph makes about research focused on the disabled person. Mr. Finkelstein has useful and innovative suggestions about expanding the scope and nature of our inquiry into disability problems. Nevertheless, there is still merit to research focused on people with are physically impaired - their problems, other people's perceptions of them and discovery of what the impaired person can contribute toward the solution of those problems.

It is well known, for example, that anything unfamiliar is apt to cause a reaction in the onlooker - be it an amputation, a robot, or someone disguised as a blob of jelly. Therefore, we might as well study and understand the ramifications of physique as a social stimulus. Problems cannot be solved by pretending they do not exist.

The physical, social and emotional problems frequently experienced by the physically impaired are more than myths perpetuated by expert helpers" who seek to justify their existence.

PHYSICAL PROBLEMS

While many agree that whether a physically impaired person is "disabled" depends in great part on the environment in which he functions, the fact remains that someone lacking a physical tool (sight, hearing, etc.) has fewer options than the able-bodied for coping with the environment and, therefore, has a higher probability of encountering physical problems.

* I thank Lee Meyerson for his helpful discussion and suggestions in writing this paper. Kerr and Meyerson are Rehabilitation Psychologists and Professors at Arizona State university.

For example, a professor in a wheelchair teaches a course on the second floor of a building that has an elevator. His able-bodied students can reach the class either via the staircase or the elevator. The professor has only the option of the elevator. Usually, neither they nor he is “disabled” in getting to the classroom. However, sometimes the elevator breaks down and the combination of his paralysed legs and the elevator’s paralysed cables creates a problem for him that the able-bodied students do not have. To be sure, the paralysed elevator soon becomes a problem for society’s maintenance men; but the professor is still left with a problem that would not exist if he had the option of running upstairs. Although society can and should do all possible to eliminate architectural barriers, even in the best of all worlds, things break; and those who have fewer alternative courses of action will experience more problems.

The same point can be made in reverse. Mr. Finkelstein envisions a community that is built for people in wheelchairs and suggests that with lower ceilings and doorways, the able-bodied would become “disabled” and experience many bumps and bruises. It is doubtful that would occur. People who can walk can also sit down. It is probable that in a setting where one could function more easily from a wheelchair, people with the option of standing or sitting would quickly acquire chairs with wheels and function very well.

The idea that all physical problems of those with impairment can be eliminated through “proper” environmental design is attractive and worth striving for, but is not totally practical nor realistic. The very design that may be suitable for one impaired group may be disastrous for another. For example, in the early days of curb-cuts for wheelchairs, blind people found themselves unknowingly in the middle of streets because the cue of the curb had been removed. Different textured cement at ramps is solving that problem. However, other accommodations are not so easily achieved. At a recent meeting on architectural barriers, a representative of people with epilepsy described the danger of injury to people who fall on hard surfaces during a seizure. Among other things, she called for floors covered with soft, well padded carpeting. Members of the audience in wheelchairs sat cringing at the thought of trying to wheel a chair on such floors.

In summary, much more can and should be done to build a material environment that is flexible enough to allow physically impaired people to function with ease. At the same time we need to realise that people with more limited options for behaviour are going to encounter more difficulties and put up with more inconvenience. Rather than indicting society for failing to create a perfect world, we should concern ourselves both with removal of barriers and teaching the physically impaired strategies for coping with those that inevitably remain.

SOCIAL PROBLEMS

For many years writers have agreed that the most troublesome problems associated with physical impairment are socially mediated. Discrimination, devaluation and exclusion can be major obstacles in the paths of “different” people’s attempts to achieve their goals in life. However, to hold responsible those who research such phenomena seems a bit like beheading the messenger who brings bad news. Furthermore, in recent years, there has been an increase in the kinds of research that establish the conditions under which both the disabled themselves and the society at large can reduce the frequency and severity of social problems.

With respect to helping relationships, Mr. Finkelstein makes a good point near the end of the monograph when he recognises that everyone depends on others for help. In view of this fact, it is questionable whether the criticisms of the helpers of Phase II need be so harsh. There is an old adage in biology that ontogeny recapitulates phylogeny. Rather than looking at the Phases only in terms of the history of rehabilitation, it may be that all people who become physically impaired go through Phase II - needing help from "experts" - before reaching Phase III where they are ready to assert their independence, rights and ability for self-help. In fact in keeping with the tone of the end of the monograph, in which there is recognition that we all depend on one another, we may even envision the day of Phase IV, when the physically impaired will become - not only the helped - not only the self-helpers - but also helpers to the able-bodied in the task of building a better society.

EMOTIONAL PROBLEMS

The section on "The Misfortune of Adjustment" seems to assume that there is no personal loss in becoming physically impaired. Mr. Finkelstein's analogy of taking one road rather than another seems superficial. The concept of psychological loss implies falling below one's standards and, as such, is a highly personal event.

It is evident that many of the "losses" experienced by physically impaired people could be avoided in a material environment that allows them to function easily, and in a social environment that is free from devaluation and discrimination.

Nevertheless, even in such an ideal world, the failure of a part of one's own body can - though not necessarily - be perceived by the person as a personal misfortune or loss.

For example, suppose a person derives great satisfaction from viewing magnificent scenery and spectacular sunsets. If that person becomes blind, he or she may feel a personal sense of loss for which society cannot be blamed. Or, suppose a person feels a real sense of pride and self worth because of his or her physical strength and finely toned muscles. On becoming a quadriplegic, that person may suffer a personal misfortune, even if the environment can be controlled with electronic push buttons. It is to the credit of Dembo and others who have addressed the problem of adjustment to misfortune that we know something about the process of adjustment to even the most deep and personal losses. It is only by studying the personal aspects of loss that we gain an understanding of the conditions under which the "sufferer" ceases to suffer.

SUMMARY

The monograph does an excellent job of pointing out the ways in which society helps to produce "disability" among the physically impaired. But let's not throw out the baby with the bathwater. Physically impaired people do have fewer physical options for behaviour; there is much that they themselves can do to help alleviate the social problems they experience; they have the challenge of adjusting to some highly personal losses.

The responsibility for eliminating disability must be shared by society with its experts and the physically impaired. Neither can do the job alone.

**ATTITUDES AND DISABLED PEOPLE
A SUPPLEMENTARY VIEW**

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*Arise ye prisoners of starvation,
Arise ye wretched of the earth.*

Vic Finkelstein, a slender, energetic, and resilient young man, has a message: Down with social oppression. It is a remarkable testimony to his strength and stamina that the message comes through in the present version even after deletions and changes suggested by several small groups of bourgeoisie critics.

As a message, it is admirable. It identifies some material and social variables in the environment that impede the optimal functioning of people who have physical impairments; and it shows, insightfully and with good humour, the surprising differences in perception that result when the focus of observation changes from inadequate performance in people to deficiencies in the environment. Right on!

As a balanced critique of the present environments of people with impairments, results and effects of research on attitudes, or as a reliable, historical account of the social position assigned to congenital or adventitiously impaired persons, however, it leaves something to be desired.

Let us be clear that what we have here is a political manifesto which raises a radical and explicit standard to which militant people with impairments, suffering from unjust social and economic discrimination, can rally. It is a statement worth making. Like similar political documents identifying and protesting discrimination towards racial and ethnic minorities and women, it may have far reaching benefits in consciousness-raising and in political organization.

We should not, perhaps, attenuate the rejoicing by inquiring too closely into the degree to which the arguments are new, reasonable, or supported by empirical data; but some caveats may lend perspective without diminishing the flavor or the reality of the injustices that Finkelstein has so well described.

NEWNESS

That variations in physique have needless or irrelevant social consequences is not a new idea, of course, (Meyerson, 1948; Barker, Wright, Meyerson & Gonick, 1953). Almost 40 years ago, one of us created a shock of insight in a group raising money for crippled children "because their handicaps prevent them from going to public school" by observing that the major reason crippled children did not attend public schools was that they were barred from attendance by school administrators. That view, advanced also by many others, has now gained considerable acceptance. A recent Gallup Poll (1979) showed respondents voting 2 to 1 that physically handicapped children should be educated with other children.

The restrictive effects of the physical environment also has received much attention, worldwide, in the last quarter century. As our colleague, Is Goldiamond (personal communication, 1979), is fond of pointing out, for example, the reason why students in wheelchairs are "unable" to take chemistry or physics in college is not because the lab benches are too high for them to reach but because society has provided suitable environmental supports for some of the population and not for others. There

are no natural laws or necessary conditions that require lab benches to be 50 inches high rather than 24 inches high.

In the last 25 years, these notions have attained considerable currency in the United States. Acknowledgement of their merit and attempted remediation of discriminatory environmental and social barriers were written into laws which now require equal access to public facilities, equal educational opportunity, and affirmative action in employment for people who are physically impaired. Increasing provision of public support for "independent living" groups also has occurred. Obviously, much more remains to be done, but the critical change in focus from exclusive concern for impairments *in* the person to equal concern for remediation of the disabilities created by the social environment, and equal attention to the need for engineering physical environments that are responsive to the needs for all people, is well begun. In brief, life conditions for people with physical impairments may not be as catastrophic or oppressive as Finkelstein suggests.

Is utopia, then, visible on the horizon? Probably not. What still remains, despite his disclaimers, is the impairment per se. Physique is a stimulus for social evaluation in every culture. More particularly, if the physical tools for behaviour that are provided by the human body are valued and functional in a society, the loss or impairment of those tools for behavior is a social and operational disadvantage. It seems unlikely that vision, audition, locomotion, or prehension will become superfluous in any social order now conceivable. That reality does not have necessary psychological consequences, however. People with impairments, like every other mentally healthy person, can learn to place their highest values on what they have or can attain and lesser value on what they don't have or can't attain (Meyerson, 1955).

REASONABLENESS

The creation and elimination of disability (isolation and incompetence) in three phases is an enticing notion. There is Phase 1, at "the beginning of modern era" when cripples were more or less amalgamated with other (usually low status) members of society. In Phase 2, people with impairments became "disabled" organisms who were institutionalized and socially oppressed by the development of medical and quasi-medical "helping professions" who controlled their lives. In Phase 3, which is just beginning, able-bodies and impaired members of society will be reunified partly by changes in attitudes and attitudes research, and partly by the development and more universal distribution of new technology. Impaired persons will then no longer be oppressed by disabling social conventions and disabling environments but will be absorbed in the mainstream of social interactions.

This political-historical model of society's responses to people with impairments is linear with a specific beginning, a discernable development through a middle stage, and a final, foreseeable end. There is a hint of circularity, of course, in the utopia of the final stage which reflects the primitive utopia of the first stage.*

* Those familiar with Marxist dialectics and its earlier presentations have seen the model before. St. Augustine described how man moved from the primitive utopia of the Garden of Eden through six ages of man to Paradise. Marx's linear, economic interpretation of history portrayed social evolution from the utopia of primitive communism, through slavery, feudalism, capitalism, socialism, and finally, the withering away of the state and the utopia of international communism. (continued n next page)

Only a killjoy would remark at the absence from this account of a pre-Phase 1 in which crippled and deformed “monsters” were killed at birth, but the omission suggests that there may be other weaknesses in the model. For example, the crippled people integrated with others at the bottom end of the social scale in Phase 1 were integrated more, perhaps, in their misery, than in their social acceptance and equality. Victor Hugo (1887) described it well:

Undoubtedly they seemed very depraved; very corrupt, very vile, very hateful even. But those are few who fall without becoming degraded. There is a point, moreover, where the unfortunate and the infamous are associated and confounded in a single word, a fatal word - *les misérables* - whose fault is it? And then, is it not, when the fall is lowest, that the charity ought to be the greatest?

Given the crippled person’s more limited physical performance, and the evidence that able-bodied people impersonated cripples, it seems just as reasonable to believe that the physically impaired were preyed upon, exploited, and truly oppressed rather than integrated, in the brutish world in which they lived. Moreover, to refer to begging as a “profession” serves only to denigrate the poor and helpless for being poor and helpless unless begging is viewed as a manner of existence which beggars somehow choose independently from other alternatives.

Similarly Finkelstein’s smooth transition from the “profession” of begging to institutionalization may take some liberties with history. Institutionalization began with the insane and the retarded who are unlikely to have clamoured for “their right to live and be in the community and being seen as responsible for their actions.” Physically handicapped persons were most likely institutionalized, if at all, in public almshouses in which, again, they would have been “integrated” with the able-bodied poor.

We all know, of course, of the social welfare efforts, particularly for handicapped children, that developed and grew during the 19th Century; we know about the advances in therapy that, for the first time, permitted treatment and amelioration of many physical impairments; and we know of the “submissive patient-hood” phenomena that he, and we, now find objectionable; so the notion of a transition from Phase 1 to Phase 2 may seem plausible. We should not be misled, however, into believing that the reputedly self-sufficient crippled population he describes in Phase 1 and the “oppressed” population he describes in Phase 2 were drawn from the same universe. They are, more likely, quite different groups. The Phases may represent, not reality but only a convenient vehicle for carrying a disputable, political-economic view of history.

Phase 3, similarly, appeals to some present notions of human worth and equality, and trends towards fostering equal opportunity, that are supported by many workers in rehabilitation. Finkelstein emphasizes that people with impairments deserve the same comfortable access to public and private facilities as the able-bodied and the devaluing, exclusionary, judgmental attitudes are unwarranted. Whether technology, integration, and new ways of measuring attitudes will bring equality and autonomy, however, is uncertain. Surely they will help, but possibly there are other

(from previous page) The three schemas are similar. In each, a model is presented whereby the initial stage (Eden, primitive communism, Phase 1) is superior to succeeding stages (Mosaic law, capitalism, Phase 2), and predictive of a final future stage of utopia (Paradise Communism, Phase 3).

unconsidered variables that must be taken into account before we can dispense with the “helpers”.

STRAW MEN AND DATA

No doubt others will comment on the possible misinterpretations of some disability theory and research that Finkelstein has cited. We offer here just one quotation that suggests that his discussion of stigma is a phantasmagoria of his own creation which reads much more into Goffman’s (1963) description than is there.

Goffman states merely that stigma exists, and he describes some ways in which it is manifested, organized, and categorized. In particular, he shows that stigma may attach not to one or several groups, such as the disabled or minorities, but rather that the total number of the stigmatized can be

as high as one wanted to make it; and when those with a courtesy stigma are added, and those who once experienced the situation or are destined, if for no other reason than oncoming agedness, to do so, the issue becomes not whether a person has experience with a stigma of his, but rather, how many varieties he has had his own experience with. (p. 129).

Similarly, his interpretation of the views of Dembo et al. (1975) and Wright (1960) may be equally distorted. Dembo and Wright, important and influential “helpers” in the transition from “Phrase 2” to “Phrase 3”, are not apologists for Finkelstein’s “disability” phenomena. The adjustment to misfortune they discuss is first of all to impairment, and their incisive analyses of the sources and remedies for coping with a less than perfect world are both theoretically sound and pragmatically helpful.

Surely, if one adopts a focus which “posits the problem in society” that “logically leads to a social definition of disability.” How could it be otherwise? That formulation, however, is reminiscent of an old conundrum; namely, “if you call a tail a leg, how many legs does a dog have?” No, it is not five. A tail has anatomical and functional properties that are different from a leg. Calling a tail a leg doesn’t make it a leg. Finkelstein has many allies and co-believers who are working toward the goal of full social participation, on equal terms, of people who have impairments; but some may demur at his emphasis on social oppression. Oppression, as the term is used in “materialist” philosophy requires that one group achieve gains politically and economically by the exploitation of another group. Who gains by oppressing the impaired?

An argument can be mounted that a hidden purpose of many social welfare schemes is to provide jobs for middle-class “helpers.” Rehabilitation service in the United States, however, which is separate from the welfare enterprise, usually is not a charitable arrangement. The function of rehabilitation “helpers” is to work themselves out of a job. They are rewarded for promoting the independence and self-sufficiency of their clients, and they are not rewarded for promoting incompetence and dependency.

Additional disturbing observations and questions may be raised by psychologists and attitude researchers: What is the evidence for the assumption that if a disabling environment is remedied by new environmental control systems, people in that environment who have atypical physiques no longer will be perceived and responded to in a negative way? What is the evidence for the belief that people are unaware of,

and have no attitudes toward, variations in physique until the psychologist identifies and legitimates people with impairments as suitable “objects” for attitudes?

Facially disfigured people provide some data. There have been very few studies of attitudes toward this group of able-bodied, cosmetically impaired individuals. They need no alterations whatever in the material environment, and they do not require physical help or helpers: But that does not protect them from social, vocational, and economical discrimination (MacGregor, 1974). In technical conditioning terms, they “elicit” negative responses, often of high intensity, from others in the environment who (in Dembo’s apt phrasing) have “visual allergies”.

Present data suggest that environmental control systems, equal access, and equal opportunities foster and greatly improve the conditions of life for people with impairments, but they do not eliminate discrimination. Important problems of isolation and devaluing attitudes remain in the classroom, in employment, and in the community.

It is good and appropriate to call for changes in the attitudes of others, but how is that highly desirable goal to be achieved? One approach is to ask, “Is a person with an impairment (or seeming to have one) a stimulus for emotions and behaviour in others? If so, what are the determinants of that function, and how can the situation be altered?” That approach accounts for the design of some attitude experiments, and it seems a not unreasonable one.

In brief, “shifting the focus from disabled people and onto the material and social organisations” is necessary and desirable in its own right; but it is unlikely that the shift will in itself solve “the problem.”

Finkelstein acknowledges, in passing, the responsibility of people who have impairments to shape their relationships with the nondisabled. His thesis, however, requires him to emphasize more strongly how able-bodied people can modify their own attitudes by role playing some situations that are common in the daily lives of people who have impairments.

Another emphasis is possible and equally desirable. The individual who has an impairment need not be a slave to social conventions that injure him, nor is he powerless in manipulating the social environment. Some insightful people have learned independently, and others can be taught by psychologist-helpers, to free themselves from needlessly disabling behaviours.

As Goldman (1947), an unusually sensitive and powerful writer, described his own experiences in living with crippled legs:

I’ve discovered something else: The gym teacher was embarrassed when he began to talk to me today. It was almost as if he felt the shame that he expected me to feel. But when he saw that I was not ashamed, his embarrassment disappeared. Is that a manifestation of a kind of power that human beings hold over each other? His attitude was in my control, it was I, not he, who determined what that attitude toward me should be ... (p.95).

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A CRITIQUE OF VIC FINKELSTEIN'S *CHANGING ATTITUDES
AND DISABLED PEOPLE. ISSUES FOR DISCUSSION*

by

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SUMMARY

Changing Attitudes and Disabled People tries to make sense of the injustices suffered by disabled people through the distortions and biases of the straight world. Since those who control the lived world of physically disabled persons are predominantly non-disabled, the ways they regard the impaired and their modes of relating to them have critical effects on their lives. Little is done to accommodate to the particular limitations connected with impairment and organic dysfunctions. Both ordinary citizens and professionals have attitudes and ideas about disability that handicap disabled persons. The paper is a very lucid convincing delineation of what it feels like to be disabled, particularly if one does not interiorise the stereotype of disability commonly held by ordinary citizens. Finkelstein has succeeded admirably in setting off the sheer physical facts of disablement from the man-made creations inherent in streets, buildings and accessories designed exclusively for the non-disabled and from a narrow view of normality of human behavior.

I was impressed by the vividness and shock value of this paper. His message is not blunted by a laboratory style of reporting and any scientific pretensions. The paper cannot be easily classified by academic discipline. It carries a sense of urgency and indignation which is startlingly different from professional writing on this subject.

After exposing the nature of those assumptions that tend to degrade and disadvantage disabled people, Finkelstein goes on to deal with a number of discrete issues related to the prejudice with which the disabled are viewed. Having made the disabled into pariahs, society needs a group of professionals to provide rehabilitation services to adjust or re-adjust them to existing social and occupational conditions. Since professionals, vulture-like, live off these persons, it is too much to expect them to visualise fundamental solutions which would permanently solve the problem of disability. *Professional services* are an important part of the problem from which physically limited persons suffer. The most irksome function of professionals is that they re-inforce the false notion that the life difficulties of disabled persons reside in them rather than in the handicapping physical and social environment. The very fact of needing social services in itself is a kind of putdown.

Even liberal writers such as Erving Goffman, Tamara Dembo, Beatrice Wright and others unwittingly contribute to misunderstandings about the disabled by referring to them as deviants and by referring to their physical status as a misfortune. A never-ending series of misunderstandings result from regarding disability as inhering in the person as contrasted to viewing disability as resulting from an adverse relationship between an impaired person and his social environment. Thus, in studying disability, the indivisible unit must be the interaction between impaired person and some aspect of the environment. Virtually everyone has some kind of limitation in coping with the environment; disability only results from the unresponsiveness of the structures and persons about.

Finkelstein's fundamental approach is perceptual and phenomenological. One might call his paper a *phenomenological sociology of disability* since it traces the more or less technical terms connected with disability and concepts to the lived world in which they originated.

In spite of the limitations of the monograph developed at length below I consider it a contribution of great value. This is because it stimulates new directions in thinking

about rehabilitation which could have practical value for psycho-social services for disabled persons by re-defining the roles to be played by disabled people in society. The above summary should suffice as a backdrop for my critical comments.

PERCEPTUAL APPROACH

Finkelstein's monograph can be considered a perceptual approach to understanding disability. People in the mainstream look on from a distance at disabled persons and Finkelstein describes their perceptions as distortions of the real. That amputee is not the pathetic helpless unfortunate creature he is viewed as being. The monograph carefully erects an explanation as to how such perceptual distortions develop.

The non-disabled do not appreciate the arbitrariness and narrowness of their views nor realise the multitude of alternative perspectives by which the man with an amputation may be viewed.

Finkelstein's perceptual view is amply represented in the existing psychological and sociological literature on disability. But it is much more abundantly found in literature and drama.

I have only a layman's knowledge of such literature. Conceivably, it has been brought together in an anthology. The diary *Black Like Me* by John Howard Griffin depicted what it was like to be a negro in the Deep South in the late fifties. Griffin, a white man painted his skin black and suffered the humiliation of being treated as black. Its effect on the American people must have been considerable. Of course, this kind of literature has a long tradition. *Romeo and Juliet* is not simply a great love story but the tragedy of a family feud caused by prejudice and self-righteousness. That individuals are inhuman to each other as a consequence of bigotry, bias, self-interest, etc. is a well worked theme in civilised society. Since there appears to be no end to social injustice, explanations in the perceptual mode will continue to play a constructive role. The rich do not understand the poor. Employees do not understand the problems of management. And so on.

PHENOMENOLOGICAL METHOD

Another synoptic way of stating Finkelstein's findings is to say that he applied the phenomenological method to uncovering aspects of the taken-for-granted about disability. From this framework of fundamental questioning, Finkelstein's distinctions between *impairment*, *disability*, and *handicap* are more important than simply clarifying definitions. The prevailing notions that disability *is in the person* is an assumption that Finkelstein subjects to critical analysis. Rather than repeating what he wrote, I would prefer to paraphrase as follows. The disposition of positivistic natural science to view the world objectively and materialistically forces the clinician to think of disability as inhering in the individual, as substantive, as something to be assessed, manipulated, and alleviated. The professional worker performs these acts, without any attention to himself as a researcher or clinician who is actually pre-determining what he sees. The closest to the *real* is *impairment* because this refers to functional loss due to injury or disease. But when we get to disability, the capacity to perform cannot be assessed in terms of the person alone but depends on the assistive devices and qualities of the social environment available to the impaired person. Thus, *disability is a relationship of a person's physical capacities to the enabling potential of the physical and social environment*. By this definition even the

All-American football player is totally disabled when flying at a high altitude without oxygen and a livable air pressure. *Handicap* is another kind of relation to the environment, one involved when an impaired person competes as a disadvantage with others in various activities. Thus, a person with a visual defect which is correctable with a lens is not handicapped by the fact that there is no way for him to get to a place of employment.

Finkelstein's definition of disability is of fundamental importance and its implications for re-deploying rehabilitation energies and resources are far reaching. Actually, this process has already begun and, of course, predates the conceptual framework with which we are here concerned. In the United States political and community activities under the leadership of disabled persons are less concerned with individual clinical and remedial services provided by professionals than with practical steps of reducing the environment's impact in creating disability for impaired persons, eg. re-designing streets, public transportation facilities and public buildings to make them accessible, and lobbying vigorously to reduce the exclusion of impaired persons from the normal activities of everyday life. In all such activities, rehabilitation professionals have played a minor part - perhaps, because much of it is done on a voluntary basis.

Another implication of Finkelstein's analysis is a fresh look at the expenditures on clinical vocational rehabilitation services and a questioning by disabled persons as to whether they could be used better in other ways, eg. in the development of independent living centres, the organization of advocacy groups with paid functionaries of disabled persons, and in lobbying for more adaptive housing. I have never heard an organization of disabled people call for more or better clinical services!

LIMITATIONS OF CLINICAL METHODS

Currently, I am in the process of writing a critique of clinical services in vocational rehabilitation. I am writing about clinical services as a professional person who would recommend the redirection of rehabilitation counsellor training at the graduate level toward a model that focuses on the community as the object of study and remediation in behalf of disabled persons. Finkelstein's definition of disability is congruent with the principal thrusts of my critique. However, I do not share Finkelstein's rather univocal emphasis that the problems of disabled persons stem primarily from a perverse view that the rest of the world has of impaired persons. To the extent that perceptual views are useful explanatory concepts, I regard them as consequences of structural and ideological dimensions of society. For instance, romantic (unrealistic) individualism, distrust of social planning, and the private enterprise economic system undergird the American belief in the efficacy of *individual* clinical services for assisting disabled persons.

As often happens, the events that trigger new movements and new directions parallel conceptual developments. I doubt whether many disabled persons would articulate the kinds of explanations of their difficulties that either Finkelstein or I are offering. For the vast majority of disabled persons, the experience of strained social relations, rejection and unemployment are primarily personal and rarely attenuated or intellectualized by invoking social science abstractions. Persons with disabilities are busy making sense of their own lives and squeezing what happiness they can from a less than friendly environment. Nevertheless, many of them have a consciousness that the rehabilitation service they received had made little or no

difference in their lives. Perhaps they even sense that not only do they suffer but are often made to feel that they are the cause of their suffering. This guilt is the inevitable consequence of clinical methods that pre-suppose that social science practitioners have possession of powerful methods of rehabilitation that can be transacted with only a passing regard to the world outside the clinic.

The general malaise that disabled persons are experiencing about clinical vocational services is now acquiring a more or less systematic conceptual basis as critics from within the social

sciences analyse the historical and philosophical nature of the clinical relationship (Bledstein, 1977; Larson, 1977). Professionals in the U.S. have become a well entrenched social class with distinctive political and economic interests.

As such criticisms seep down to the majority of disabled persons, it would have the effect of articulating and giving form to what was formerly vaguely felt. It is bound to influence the status of rehabilitation professionals. Professional roles, job titles and credentials all serve as masks behind which activities of vital concern to clients are partially known. Therefore, we can expect that disabled persons and their advocates will ask many questions about rehabilitation practices that professionals would rather ignore or treat as in-house issues.

FINKELSTEIN'S DISAGREEMENT WITH TRADITIONAL SCIENCE

At first sight, it appears that Finkelstein is quibbling about the limitations of the professional and traditional perspective on disability, but, this view cannot be sustained by anyone familiar with the common criticism of positivism as a philosophy of science. In brief, Finkelstein's criticism is that of the phenomenologist who insists that science is essentially a human enterprise and its aims and methods must ultimately make sense in human terms. The relationship between professional helper and disabled client is not the same as the relationship of the natural scientist and the objects of science. A human relation is unitary, interactive, and dynamic. Therefore, in this integral professional-client relationship, the *real* and the *significant* is not simply out there as in the test-tube or in the client, but also in the professional person and the character of the relation. Only the sanctimoniousness of some practitioners and researchers could prevent them from acknowledging this.

Traditional natural science located the essence of disability in disabled persons - thus overlooking the relationship factor with the non-disabled, and especially the fact that research into disability has become a business with discernible vested interests. Establishment science has deployed virtually all its resources in studying disability and rehabilitation as clinical enterprises, that is, *as if the individual suffered a disease called "disability"*. This

perspective of researchers is attributable to many factors, of which economic self-interest is only one. In the United States, social science researchers go through a lengthy period of apprenticeship during which signs of non-conformity with the establishment's view of science are squelched. Many academic journals, for instance, reject manuscripts which lack empirical data. Until recently, anyone raising issues concerning the relation of philosophy to scientific methods was regarded as woolly-headed. This line between ideological persuasion and conscious self-interest is not as clear to me as it seems to Finkelstein. Thus, I find myself more optimistic

than he concerning the prospects of winning over colleagues to his perspective on disability as an interactional phenomenon.

American psychology should not be regarded as being crudely empirical. There have always been minority movements anchored in philosophical psychology and social psychology that tried to pull psychology away from its parochialism and relate it to larger intellectual movements. Unfortunately, these movements have had far less influence in the development of clinical methods in vocational rehabilitation than has the medical model. Thirty years ago, efforts by some leaders in the American Psychological Association to direct clinical psychology along a path independent of medical tradition were largely ignored. Organized psychology and organized sociology in the United States is being challenged by radical factions which tend to keep the conscience of these disciplines alive. Professionals in rehabilitation should align themselves with these movements for inspiration and strength. Unfortunately, Finkelstein glosses over cross currents in the social sciences and thereby creates an impression that the picture is all black. In the United States, those psychologists who are deeply conscious of the values implicit in the various aims and methods of psychology find themselves in conflict with those striving to enhance the status of practitioners for its economic returns.

It would be a mistake for Finkelstein to assume that there is only one kind of psychological research and practice - the clinical mode. Social scientists are recognising the limitations of a single discipline and engaging in team research. The potential of social science for helping disabled persons is difficult to assess but it is not as bleak as the Finkelstein monograph implies. And this brings me to the most vulnerable feature of his thinking, namely, his in-ability to visualize a role for the professional researcher and practitioner in creating more favourable attitudes for disabled people.

THE DIVISION OF LABOR

As Finkelstein points out, the existence of a large class of physically disabled persons was made possible by revolutionary discoveries in medicine and the comparative independence of even severely disabled people by engineering applications of electronics and bio-mechanics. Finkelstein mentions this is passing and take takes no account of it in his discussion of professionalism. But the division of labor has affected those who apply knowledge as well as those who generate it.

During the 1960's in the United States, the attempt to induct indigenous leadership into local anti-poverty programs was marked by incompetence and scandal. Independent living centers for the disabled while widely heralded as a new hope are now having difficulties in securing competent leadership and in training them. To those who are left out in the cold, it makes little difference who is to blame. Clearly, having a background of deprivation does not guarantee that the disabled persons in charge will be honest or competent. Racial minorities, the poor, and the disabled may generate their own exploiters, and their own brand of incompetence. Managing a service program requires bureaucratic skills, the recruitment and holding of persons with expert knowledge and skills, and public accountability. Bearing in mind that in general the unemployed disabled are those most disadvantaged and least integrated into mainstream society, we should be cautious in assuming that disadvantaged disabled persons can run their own enterprise of remedial services in our present-day expert society. I am somewhat concerned about the strain of anti-

intellectual distrust of every paid rehabilitation functionary discernible in Finkelstein's paper. Unfortunately, it is sure to strike a responsive note among those most frustrated by the unresponsiveness of their environment. But that attitude would also repel rehabilitation personnel who would seek out a more congenial setting in which to work. Disabled persons need not choose between rejecting professionals and being subjugated by them.

The conflict of interest between client and professional is drawn by Finkelstein in sharper terms than reality justifies. Most psycho-social workers in rehabilitation are salaried and virtually all of them could find comparable employment outside the field of rehabilitation if need be. If reality were indeed as he described it, then one would have to expect much more hostility between the disabled and service providers than actually exists. One result of his conspiratorial theory is that physically disabled persons appear to be unique victims of a unique group of exploiters. By contrast, in the expert society, *everyone is victimized by having to lend himself to the mercies of the expert* including having to give him/her a blank check for services rendered. Further, the consciousness of helper and helpee and their distinctive role relationships are not as clear as he assumes. That is because in a competitive hierarchically arranged society, almost everyone carries out roles of the exploited and the exploiter. The particular social mechanisms by which the physically handicapped are degraded are not as clear to me as they are to Finkelstein. It is difficult to identify the enemies of the physically disabled. A monopoly that keeps the price of wheel chairs very high, the town council that refuses to construct curb-cuts on sidewalks, and a corporation that does not hire any physically handicapped persons are examples of enemies. But the range of contact between disabled and non-disabled is vast and therefore it is difficult to pinpoint the enemy. An upwardly mobile young man or woman not only avoids making friendships with disabled persons but also with most racial minorities, the poor, the physically unattractive, those with unpopular political beliefs, etc. Is this person degrading the disabled person or is he pursuing his ambitions of success?

The bureaucratic complexities of modern society are such that the disabled have few clearly defined enemies. Like other disadvantaged persons, they exist in a Kafka-like world, sensing only that they lack something that others more fortunate possess but are not sure what it is nor how to come by it. That is a far cry from chiaroscuro sketched by Finkelstein. He works attitudes toward disability too hard and I see a flaw of reductionism in his work.

Similarly, his cavalier dismissal of professionals ignores the division of labor in the knowledge industry as an irreversible feature of our society.

The origins and maintenance of prejudice is not easily explained. But for me, essential explanatory dimensions must include a theory of society including politics in the literal sense of the sources of power, economics or the exchange of goods and services, and the role of ideologies in concealing the real mechanisms that keep a society functioning in a coherent way. The foregoing is not an intellectual exercise by which to understand the position of the disabled in society. But properly applied, such understanding may suggest logical steps by which disabled persons can improve their status. The disabled must seek out their natural allies.

I do not expect the development of a distinct constituency of the disabled to be *the* solution. The *American Coalition of Citizens with Disabilities* is willing to establish an *ad hoc* relation with any group on any issue with which it shares a common position.

Among the professionals are a sizable minority of persons deeply committed to disabled people.

Finkelstein looks back nostalgically to the time when there were no rehabilitation experts. In those days impaired persons were integrated into the community and there were no special interests determined to institutionalize them and make them dependent. (I do not get the same impressions from my reading of history, particularly with respect to the mentally ill). It is precisely a relatively high standard of living made possible by the division of labor that enables persons such as ourselves to consider the status of disabled persons in the economically advanced countries of the West. In creating the impression that rehabilitation professionals have no redeeming qualities, Finkelstein adopted a Luddite approach. It is more rational to make professionals be more responsive to the needs of disabled persons and to work toward ensuring that credentialed or licensed professionals carry on their functions in the public interest.

The costs of involved in getting rid of our experts is too great. *But experts need not be in control.* For example, engineers are firmly controlled by their corporate employers. In England, physicians earn most of their income from the government. In most states of

the U.S. utilities are controlled by citizen commissions notwithstanding the technical decisions they must make. The business of taming professions long accustomed to operating as closed fraternities is not easy. We must make professionals more accountable without, however, frightening off the competent and the ambitious, and without the illusions that the professionals would perish without the disabled persons to feed on. When we examine the broad band of professionalism in the U.S., those in the rehabilitation business are probably *less* affluent and *less* guilty of pursuing self-serving goals than most sectors of professionalism.

It is not quite fair to criticise Finkelstein for failing to write what I would have. However, assuming Finkelstein's monograph has achieved its desired shock effect and mobilized citizens to action, what kinds of service functions would he assign to psychosocial workers in rehabilitation and how would he ensure that they performed properly and without the harmful effects which they presumably have on their clients? I do believe many professionals would want to join him in this kind of dialogue.

Finkelstein regards professionals in rehabilitation as if they were autonomous in the manner of physicians and lawyers in private practice. But rehabilitation professionals are employees of government and private agencies very much as most engineers are. As employees, they usually perform in the ways prescribed by their agencies. Behind rehabilitation practices are institutional policies and practices. In fact, the most common complaint of rehabilitation counsellors is that the requirement to function within institutional guidelines deprives them of their professional judgment. Pinning the bad guy label on professionals as Finkelstein does thus disregards the great difficulty of localizing responsibility in a highly complex bureaucratic society. After 20 years of association with the California Department of Rehabilitation, I find it difficult to state in a simple succinct way the measures needed to resolve the criticisms made of this agency by disabled persons.

There are undoubtedly some regressive features in professionalism. But I doubt that this fact should loom large in understanding the degradation and deprivation

suffered by impaired persons. A competitive society hierarchically arranged by income,

privilege, and status tends to ensure that disadvantage and helplessness will be perpetuated. The plight of disabled persons is only one sector of many needing redress in our society. Trying to discover just who is responsible for the dependency and other negative features of the status of the disabled might be an unproductive question to pose. It might be preferable to proceed with specific reforms and to determine who is opposing them. Disabled persons may very well discover that experts qua social scientists, some administrations, and most practitioners will be on the side of the angels. Through this pragmatic approach, the disabled can sort out their friends and enemies.

WHO ARE THE OPPRESSORS?

It is many years since I read Goffman's *Stigma*, but I have no recollection of anything in it to suggest that he condones the oppression of stigmatized persons, except perhaps that connected with crime. In belaboring Goffman, Finkelstein appears to engage in the ancient custom of slaying the bearer of bad news. Pointing out the universality of stigma in all known societies is not the same as condoning it.

Finkelstein has not progressed beyond the abstractions by which he codified ways of viewing disability. His conceptual picture is clearer in the abstract than through his attempts to apply it in the real world. In modern bureaucratic society, it is difficult to finger the sources of power, influence, and decision-making. In addition, because such societies are hierarchically arranged, most persons enjoy some privileges that others do not and thus the desire to change societal arrangements are experienced most strongly by those who are most deprived and least capable of effecting change.

The fact that the disabled themselves are dispersed throughout this hierarchy is a significant fact that hinder the disabled as a group from effecting desired societal changes. On the other hand, a disproportionate number of the disabled by reason of discrimination are found at or near the base of the hierarchy and it is this that makes them a potential constituency with similar interests. To the extent that disabled persons act as a coherent lobby in furthering their common aims at the community and higher political

levels, they would be implementing the basic view of disability that Finkelstein has advocated. But to do this, they must increasingly wean themselves from the lure of vocational rehabilitation via the clinical individualistic route. On this score, we are indebted to Finkelstein for so clearly pointing out the very high price impaired persons pay for their excessive reliance on clinical services.

There is enough truth in Finkelstein's making the professional the *bete noire* of disability to think about this seriously. There is no doubt that rehabilitation professionals have tended to control the use of public funds and control the direction of all aspects of rehabilitation. But in this, they have not differed from physicians, lawyers etc. and for that matter from corporate vested economic interests. One could come away with the impression that disabled citizens suffered primarily from professionalism. The division of labor in industry made us dependent on others for making goods. More recently, the division of labor in the knowledge industry has made us dependent on a wide range of knowledge experts. Rehabilitation

professionals do not simply exploit disabled persons they render useful services. How to retain the practical advantages of the division of labor without any one group taking an excessive share of the common pie is perhaps the number one problem of Western democratic societies. Seen in this context, disabled persons in using professional rehabilitation services are in the same position as other citizens who have recourse to them. In the U.S. lawyers and physicians, for instance, exert an influence in the American economy and on social policies vastly out of proportion to their number and to the true significance of their disciplines. Disabled persons cannot control professionalism by themselves. They must find natural allies among other disadvantaged groups eg. racial minorities, the unemployed, the poor, and the aged. All these groups suffer alike from an exclusively profit-orientated economy and the devices it uses to ensure an abundant supply of cheap labor.

DISABILITY AS A PARADOX AND AS AMBIGUITY

At several points in his monograph, Finkelstein refers to the disability situation as a *paradox*. I am puzzled by this designation for several reasons. To me, a paradox is a phenomenon that defies logical analysis or that disagrees with direct consensual experiences. But, Finkelstein has made a most effective case in clarifying the parameters of the disability situations; disability is not to be found in the client or the other but in the relationships, or in the way two persons (one of whom has an impairment) interact. He has clarified that the essence of disability is not an absolute but varies with the social milieu. Finally, Finkelstein has exposed the false claims of practitioners and researchers who presume to describe their clients objectively without a specific evaluative framework.

I have wondered why Finkelstein did not refer to the disability situation as an ambiguous one. There are elements of ambiguity in most human relationships, just more of them in a disability relationship. In a disability situation, we have to reckon with numerous personality factors, racial and cultural differences, social economic factors among many. When the impaired person experiences false attributions from the other one, he is not usually certain concerning their origin and significance. Let us assume we are dealing with a negative attribution to a person seeking vocational training or job placement. The negative framework may be based on the exaggeration or spread of the visible impairment but it may also be influenced by many more factors that are not unique to being impaired. Unfortunately, since many impaired persons suffer from multiple career disadvantages, the precise influence of each one in a human situation is not easily assessed by the impaired person. Incidentally, one of the purposes of individual and group counselling is to assist impaired persons in coping with ambiguity and turning it to their advantage.

Another aspect of the ambiguity of disability is the difficulty of sorting out the disadvantages suffered by an impaired person that might explain his current difficulties. If we are talking about a congenitally impaired young adult, he may have unrealistic vocational goals due to a lack of important social skills. Most of his present dilemma may be due to his segregated education, overprotection, a non-accepting social environment etc. but possibly very little to fundamental character limitations.

In a third sense, we can regard the client-professional relationship as an ambiguous one. The fact that these two persons are together has no inherent meaning and purpose; the meaning and

direction is supplied by the professional and consented to by the client. Let us suppose that after the first traditional session, the client started a detailed enquiry into the professional's methods and competence. Such deviant conduct would highlight multiple new meanings in the relationship which hitherto were just possibilities. Of course, there are various professional rituals to forestall such contingencies in the form of waiting rooms, titles, credentials, office furnishing etc. to ensure that clients are properly subdued before entering the relationship. Nevertheless, in the United States there are evidences of the increasing strains between professionals in most fields and their clients. One view of this strain is the manoeuvring to manipulate the ambiguity of the relation. Conceivably, the fact that society diminishes the status of disabled persons on the one hand and provides rather costly services to rehabilitate them on the other might be considered a paradox. While I have no facile explanation for this apparent paradox, I believe that subject is amenable to study and analysis and elsewhere I have speculated about this matter (Stubbins 1 977).

Another apparent paradox is the hate-love complex that often characterises the relationship between client and professional. Particularly in the United States where there is an inordinate prizing of independence and a widespread illusion that the most successful persons are not dependent on others, helpee-helper relations have ingredients of love and hate, admiration and resentment, as well as other bi-polar attributions. Years ago when I was a regular reader of the American news magazine, *Time*, I observed how it appealed to this dualistic attitude towards the greats who got into public attention by describing the personage in glowing terms and then showing a photograph of him sprawled on the sidewalk because of having slipped on a banana peel. Similar ambivalent attitudes may be found also in the helper who on the one hand enjoys the intelligence shown by the client in appreciating his expertise and on the other, has a certain contempt for his being so easily manipulated.

The epistemology of positivistic natural science finds it awkward to cope with the above kind of dialectic relations. Only against the background of positivistic science, can I make some

sense of Finkelstein's repeated description of disability as a paradox.

ADJUSTMENT TO MISFORTUNE

This section of the monograph is a digression from the significant themes Finkelstein has raised. Having to adjust the misfortune and stigma is an inescapable fact of almost everyone's life. Everybody's identity is or eventually becomes an object of pity or diminution by the standards of the majority of the community. In this regard, I fail to see how the impaired differ from those suffering the "misfortune" originating from being of a minority race or religion, being old, poor, uneducated, or ugly.

I can't see where we can go with Finkelstein's cogitations about misfortune. I would have preferred to have him further develop standards for a productive relation between impaired clients and experts in rehabilitation.

Finkelstein's criticism of the considerable amount of academic work that has gone into the study of attitudes toward disability, is damned on the grounds that impaired persons by becoming objects of study are thereby institutionalized. But, I believe a more relevant criticism is that in relation to the massive problems daily experienced by impaired persons such academic work tended to be trivial and scientific. Only

academics can afford the cost-benefit of empirical studies on attitudes toward disability because these are judged by in-house standards of academic orthodoxy, and are rewarded by promotions and visibility in the academic community. Finkelstein is perhaps one of the few disabled persons who has taken any notice of them!

CONCLUSION

Finkelstein's monograph illustrates the strength and weakness of the existential phenomenological method in the search for fresh understanding. Finkelstein has demonstrated clearly, incisively and convincingly that mainstream knowledge of disability is tainted by the phoney objectivity of researchers and the practitioners of rehabilitation and that new truths emerge in suspending the "scientific" attitude and assuming the imaginative one that

Finkelstein does. He has begun to develop a sociology of research and practice concerned with rehabilitation.

The notion that stigma was invented at a certain phase in evolution to ensure that *disabled* persons would not break out of their low social status seems like a speculation based on personal grievances rather than a sober consideration of the real sources of deprivation suffered by impaired people. Similarly, his acerbity toward rehabilitation professionals seems based on their being near-at-hand. Finkelstein's strong feelings may also be a reaction to the authoritarian class-conscious spirit that characterizes the delivery of public rehabilitation services in England. In the United States, on the other hand, a kind of populist ethos prevails. Bitter critics of comparable services in the U.S. are more apt to complain of their ineffectiveness and irrelevance than of exploitation and fostering dependency.

I understand that Finkelstein's monograph will be studied by concerned persons in a number of Western countries. No doubt, personal reactions to it will be influenced by the nature of rehabilitation services in the various countries and especially by opinions of the changes needed to improve them. In short, each of us has our special hidden agenda. This may be as crucial in understanding the reactions to the Finkelstein monograph as our proffered ideas. Thus, while I tend to share his critical attitudes toward rehabilitation professionals, our respective reasons might be quite different. Difficulties in communications are further compounded by the connotative baggage that critical terms acquire in different countries. Even the term "vocational rehabilitation" suggests various nuances in the countries of Western Europe.

Apparently, the exploiting professional role would vary as we make comparisons across countries. When we trace the abstraction to the life dimensions in the U.S. we might find something like this: A physician, social worker, psychologist, or rehabilitation counsellor who puts in 35 to 40 hours a week, making an average to below-average salary prevalent in his profession, trying to help specific disabled individuals with problems similar to those presented by others with somewhat different kinds of social handicaps. The notion that he or she is in any sense exploiting should be traced to the role relations sanctioned by the larger society and is

not specific to the category of disabled persons. Professionals undoubtedly enjoy certain prerogatives and higher incomes not common in the labor force. Further, the

character of the client-professional relation tends to be one-sided when the client is an individual rather than a corporation.

The more powerful professions command the kind of unrestrained power that corporations lost 100 years ago in the United States. But Finkelstein has not made a convincing case that disabled persons suffer on this score more than other disadvantaged groups.

One final reflection. Finkelstein's monograph raises the perennial question of how to translate a good idea into effective action, since the scotoma inherent in the clinical attitude in rehabilitation in the U.S. and the latent corruption of professionalism need to be converted into practical issues that can be dealt with at the policy and action levels. And we should get on with that agenda.

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RESEARCH UTILIZATION CONFERENCE

List of Participants

Reactions to the Monograph

Critical Issues For Discussion

WORLD REHABILITATION FUND
INTERNATIONAL EXCHANGE OF INFORMATION
IN REHABILITATION
SEPTEMBER 5-6, 1979 KNOWLEDGE UTILIZATION CONFERENCE
“Changing Attitudes and the Disabled: Issues for Discussion”
INSTITUTE OF REHABILITATION MEDICINE
NEW YORK, NEW YORK

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SOME CONFEREES' REACTIONS TO THE MONOGRAPH

A research utilization conference was held on September 5-6, 1979 to which 22 individuals representing the following rehabilitation segments were invited: research, education, state vocational rehabilitation, disabled population, research utilization, Rehabilitation Services Administration. All of the conferees had particular interest and expertise in the area of attitudes. The purpose of the conference was to call upon their interest and expertise for the purpose of reacting to the ideas presented in the monograph and by Finkelstein in person, as well as to recommend action steps.

Before the conference got underway, conference participants were asked to write answers to this question:

Did the participants of the conference approach rehabilitation differently before reading the monograph than they are planning to approach it now after having read the monograph? Concretely, did they learn before and do they learn now toward seeing the disability seated in the impaired person or primarily as a result of the physical and social environment constructed and promoted by able-bodied people?

(Question raised by Tamara Dembo).

We are including in this section for the reader some representative responses.

In some cases the names of the authors of the responses which appear below accompany their comments. In other cases, the responses were written anonymously, and therefore no name appears.

"Yes, it definitely influenced how I looked at disability. The Finkelstein monograph stated what was previously vaguely articulated into a series of themes that should be considered and discussed by all serious students of disability.

It is a clear statement of a social-psychological point of view of disability. Admittedly, Finkelstein did not *invent* this perspective. But he applied it in a provocative and scholarly way.

Unfortunately, it is enmeshed in a number of side issues which tend to detract from the central value of his contribution.

Finkelstein has convinced me that the sociology of the science of disability is an important subject in its own right."

Joseph Stubbins

"Reading the monograph did *not* change my basic thinking, but did highlight what to me are the dangers of asking either-or questions - or viewing the world that way. To me, "disability" is a *complex* function of the individual's physical impairment, self-attitude, environment and social attitudes (both *re* the disabled in general and the given person in particular). Simplifying more than this is oversimplifying, and not helpful."

“There has been a certain sharpening of my existent orientation as this position has been my own and has amply been expressed in my own writing and teaching. In brief, I believe the Finkelstein position is one that does not differ from what many of us have been saying and doing for years. It has the virtue of strongly and in places effectively presenting what to me is an essentially valid position. By putting it into an unnecessarily confrontational posture, it serves to distract and doesn’t give credit to what we have done.”

Jerome Siller

“Yes, it deepened my own perspective and gave to me, for the first time, some external reinforcement for my own thoughts on disability/impairment relationships. Less politely, I was glad to have someone take Siller and Kleck to task at the level of scientific objectivity. I can now read a work on ‘attitudes toward disabled’ and tell if the person writing it is ‘disabled’ him/herself. The monograph confirmed my instinct.”

Susan Daniels

“Yes in the sense that the approach stresses the social and cultural elements of the relationship between functional impairments and the environment. Apart from a legislative effort to change the conditions of the disabled, these elements have been muted in the therapeutic situation. Finkelstein paper provides an emphasis and a context which is particularly timely and useful.”

"No. The ideas have been around and sometimes strongly presented, for at least thirty years. A stronger presentation might have resulted if that fact had been recognized.

There are two aspects to disability. The social stimulus value of the person is one – and it is a very important one, but there is something more to disability than a social relationship, namely, physique provides tools for behavior and disability is defined in one important respect as the loss of a tool for behavior.

The consideration of attitude research is perhaps the weakest point in the monograph. It is peripheral to the main thrust and less than a reliable or reasonable approach to the topic.”

“Perhaps the monograph made me think more about the interesting relations between historical events and the position of people with disabilities in Society. As for the specific question regarding the relative emphasis on person and environment, for the past several years I have been investigating and writing about such an attribution question, arguing that ‘environmental accommodation is at least as important as personal adaptation and often more so.’ In this regard, the monograph has not altered my views. The fact that the monograph ignores the person in the equation “Behavior is a function of the person and the environment”, in my view does not further understanding of problems related to physical impairment, and in fact impedes understanding.”

“Yes, the monograph influenced my stance on the person-environment attribution of the source of the disability; but not so much in switching it from p to w but strengthening an already slightly (but theoretically) e-oriented attribution. What I found most cogent in the monograph were the concrete examples (e.g., analysis of the social and environmental contingencies washing one’s hands). These helped to convince me of what I ‘philosophically’ espoused but perhaps could not very well explain to myself or others.”

“Attitudes Toward the Disabled”

CRITICAL ISSUES FOR DISCUSSION

1. How would the training of rehabilitation personnel in psychological aspects of rehabilitation differ if disability is seen as a characteristic of the person or if disability is seen as a product of environmental circumstances?

2. *The issue of person and environment:*

Under what conditions should one emphasize the social and physical environment, or intrapsychic phenomena (i.e., the person), or both person and environment in researching and applying knowledge to problems involving physical impairment?

3. If we eliminate the social implications, is or is not a serious physical or mental impairment a personal misfortune?

4. *The issue of normalcy and standards:*

In the ideal society, can notions of normal standards and values involving normalcy be eliminated as problems in rehabilitation?

5. What are the conditions under which clinical or counseling intervention might be seen as appropriate and/or necessary even though one's general approach places the disabling problems mainly within the environment?

The nature of the helping relationship in phase 3:

What is (or should be) the nature of the helping relationship between client and professional (counselors, doctors, teachers, physical therapists, etc.) in phase 3?

6. *The recognized and unrecognized ways by which professionals misuse their positions of authority and trust.* These abuses differ from country to country and thus provide an arena for cross-cultural comparisons. Delivery systems of rehab services are not only technical questions but also distinctive cultural products and therefore resistant to change. Americans have tended to view rehab problems as technological ones and ignored their cultural contexts. **WHAT BENEFITS MIGHT ACCRUE FROM VIEWING REHAB PROBLEMS AS SPUN BY AMERICAN CULTURE RATHER THAN EXCLUSIVELY AS TECHNOLOGICAL ISSUES?**

7. In what way can psychologists, and especially disabled psychologists, best participate in rehabilitation from the standpoint of the environmental approach? Would their contributions differ from those which they would try to make in concentrating on the impaired person as the carrier of disability rather than on the physical and social environment?

8. **HOW CAN A PHENOMENOLOGICAL SOCIOLOGY OF DISABILITY UNEARTH THE SOCIAL PROCESSES BY WHICH IMPAIRED PERSONS ARE SHUNNED AND DEVALUED?**

9. *The difference between the phenomenology of disability and the scientific science of disability.* Finkelstein makes it difficult for researchers, practitioners and administrators to pursue the typical modes of rehab with the innocence they have until now. It is the first order of true science to identify orientation and bias.

WHAT NEW IDEAS ARE GENERATED BY THIS FRESH PERSPECTIVE?

10. The possibility of seeing prejudices or stigma as seen by Erving Goffman in notes on *The Management of Spoiled Identity* as being subliminal when applied to professional or lay workers as they work for the disabled.
11. What personal or political measures should impaired persons take now and in the future to assure that society at all levels responds to them in egalitarian and non-stereotyped fashion?
12. Since remedying the social oppression of the environment will necessarily be an evolutionary process, what measures can educators and researchers take during this period of change to educate helpers and provide policy makers with needed information which will lead to movement to phase 3.
13. Since the environmental changes required to remove the “oppressive” character of our present state will involve substantial political and economic changes, what strategies will facilitate such change?

How can the elimination of the social oppression for the physically impaired be done so that the plight of the aged, mentally retarded, mentally ill, under-educated, and other deprived individuals are also given equitable treatment?