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Running head: DEFINING DISABILITY IN AN ABLE-BODIED ENVIRONMENT

Role-taking vs. cultural identity: Defining disability in an able-bodied environment

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Abstract

Are people with physical impairments seen as a minority group or as individuals who take on the role of being disabled only in certain circumstances? While minority group membership has a variety of social, psychological, and legal advantages, it forces people to give up some individuality and gives the disability a more permanent connotation (Berbrier, 2004; Watson, 2002). Alternately, viewing disability as a role, and attaching the label "disabled" in certain circumstances, allows for a broader spectrum of individual choice. However, the label assumes someone who is disabled to be "less than able," thus carrying a strong stigma. Through my personal experience with a temporary disability, I examined the labels placed on people with physical impairments, both by the individual and by society in general. I conclude that the lived experiences of those with disabilities do not demonstrate that people with physical impairments self-identify as a member of the disabled community, but that they take on this label only when the environment fails to meet their needs.

Introduction

In September of 2004, I missed a step while walking down the stairs and broke my ankle severely enough to need a wheelchair for five weeks. Through this experience, I became acutely aware of how my disability was viewed, both by myself and by society. This paper combines my own ethnographic study of living as a disabled person with secondary analysis of the experiences of others who have also lived with a physical impairment. The purpose of this paper is to examine how, and by whom, disability is defined. The first section of this paper reviews the models underlying classification and labeling of disability status. The second section describes the methodology used for this research. The third section incorporates my experiences with the lived experiences of other people with disabilities. The fourth section examines those personal experiences within the context of the given theories. The conclusion suggests implications of viewing disability within each of the discussed frameworks, including implications for both policy reform and language usage.

It is important to note that disability can take many physical and mental forms. My experience dealt only with a physical impairment, and thus, for the purposes of this paper, mental impairments will not be considered. In addition, "disability" is a frequently used term in this paper. As one of the main purposes of this research is to understand the definitions of this label, its primary use in this paper is for simplicity rather than accuracy.

Literature Review

How the term disability is defined has serious implications for the disabled community. In an attempt to define disability, researchers within the field of Disability Studies have

primarily focused on two major theoretical models: the medical model and the social model (Kaufman-Scarborough, 2001). Each model uses different criteria to identify someone who is healthy, and therefore determine disability status.

The medical model bases judgments solely on the physiological state of an individual. However, symptoms are identified, reported, and diagnosed differently in different cultures (Weiss & Lonquist, 1997). Within the medical model, disability is defined as a failure of an individual's body to meet normal standards (Kaufman-Scarborough, 2001). Parsons (1972, as cited in Weiss & Lonquist, 1997) describes disability as a role an individual acquires upon becoming disabled. He equates having a disability to being sick; individuals should want to get better and should not exploit any advantages they may receive because of their illness. The disabled are expected to want to change this state and should strive to achieve "normality." Though the theory of disability as a role may better explain how an individual feels while dealing with a disability in life, the attempt to generalize the sick-role theory to disability may be inaccurate because people cannot always return to "normal" medical status (Thomas, 1966).

Unlike the medical model, the social model concentrates on an individual's ability to successfully function in certain circumstances or perform usual tasks. It also takes into account the subjective nature of defining health. Thus, health is, "the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized" (Parsons, 1972, as cited in Weiss & Lonquist, 1997, p.126). The social model argues that disability is defined by society and the environment in which a person lives. Kaufman-Scarborough (2001) describes people with disabilities under the

medical model as being, “oppressed by societal views of normality” (p. 434), and opts for the social model because it focuses on how the environment disables otherwise healthy and able individuals.

Recently, the idea of viewing disability as a cultural minority has also gained popularity. Wirth (1970, as cited in Wertlieb, 1985), defined a minority group as, “a group of people who, because of their physical or cultural characteristics, are singled out from others in the society in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination” (p. 34). While minorities frequently unite over shared feelings of oppression and lack of power, the size of a group does not affect its ability to be considered a minority (Berbrier, 2004; Wertlieb, 1985). At times, minority groups form only as an attempt to alter this power difference and receive acknowledgement and respect for their group (Berbrier, 2004). However, who defines these groups is not always certain. Regardless, these groups are assumed to be disadvantaged in some way when compared to the dominant group.

Having seen that disability can be defined in several ways, the central research question of this study is: How is disability viewed by individuals with physical impairments, as well as by the general society? This broad question is analyzed through five sub-questions:

- 1) In what ways can “disability” be viewed as a temporary role?
- 2) In what ways can “disability” be viewed as a fixed status?
- 3) How do individuals with physical impairments view their own lived experiences and define themselves?
- 4) How does the general society label people with physical impairments?

5) What implications do each of the various disabled labels carry?

The first two sub-questions are discussed in the following literature review. Questions three and four are explored using six studies in the Discussion section. The fifth sub-question is investigated in the conclusion of this paper.

Disability as a Role

In regard to the first sub-question that seeks to investigate the ways in which disability can be viewed as a temporary role, it is noteworthy to mention that several researchers have explored the idea of disability as role, or a position individuals occupy that may change over time. Key among them is Parsons, who believed all societies contended with the issue of people feigning illness as a means to gain advantages such as control over others' actions and attentions (1948, as cited in Curry, Jiobu, & Schwirian, 2005). Gray (1965) agreed with Parsons and added that some individuals may be hesitant to relinquish their sick-role because they prefer the benefits of their incapacity to the costs.

In order to confront this problem, Parsons (1948, as cited in Curry et al., 2005) listed a set of four responsibilities that people who are sick should follow in order to avoid appearing as if they are exploiting their illness. First, society must understand that people who are sick did not choose to be that way and should therefore not be held accountable for their condition. Second, it should be acceptable for people who are sick to withdraw from the activities of healthy individuals without punishment. Third, people who are sick should want to return to "healthy" status because being sick is an undesirable state. The fourth requirement is that people who are sick should work with medical professionals in order to alleviate themselves of whatever sickness ails them. If

an individual does not meet these requirements, he or she will be, “stigmatized as a deviant” (Parsons, 1948, as cited in Curry et al., 2005, p. 628).

While some researchers argue that Parsons’ sick role applies to the disabled, others deny this claim. Specifically, Parson’s opponents state that although the release from responsibility a disabled individual is allowed may help him or her in certain situations, being, “exempted from normal social roles” (p. 59), may actually increase the power of the stigma attached to disability (Hanna & Rogovsky, 1991). In addition, Silvers (1996) argues that by expanding Parsons’ theory to disability, it becomes viewed as a sickness, demonstrating society’s negative view of the physically impaired. Because disability often carries stigma and many people with disabilities can never fully recover to normal standards, Parsons’ theory may not be applicable. Indeed, Zola (1993) states,

In the case of a person with a chronic illness and/or a permanent disability, these traits once perceived to be temporary accompaniments of an illness, become indelible characteristics. ‘The individual is trapped in a state of suspended animation socially, is perpetually a patient, is chronically viewed as helpless and dependent, in need of cure but incurable.’ (Zola 1993:17)

When people who are permanently disabled are viewed through Parsons’ sick-role theory, the role they assume is no longer fluid, but fixed (Marcus, Seeman, & Telesky, 1983). However, Parsons (1972, as cited in Weiss & Lonnquist, 1997) maintained that his theory was indeed applicable to the disabled because even people who cannot fully recover can still function in many of the same ways they did before they became disabled (or can at least fulfill many of the duties required of individuals without disabilities).

In examining the ways in which disability can be viewed as a temporary role from the social model, Skar (2003) notes that disability is a role determined by the environment. He asserts that a physical impairment alone does not make someone disabled. Rather, the role of disabled can be taken on when an individual with a physical impairment encounters a barrier to accessibility. When this person is no longer able to perform certain functions because of how the environment interacts with his or her impairment, that person takes on the disabled role. Upon doing so, that person is not necessarily identifying as sick, unhealthy, or less-than-perfect; the environment is simply “disabling” him or her. The individual is just as able as his or her “healthy” peers to complete most tasks and is therefore not disabled in everyday scenarios (Skar, 2003). Thus, when a barrier in the environment makes someone with a physical impairment unable to function, that barrier is “dis-abling” the person.

Disability as a Cultural Minority

In regard to the second sub-question that seeks to investigate the ways in which disability can be viewed as a fixed status, cultural minority theories show that disability can also be viewed as a master status of an individual that cannot be disregarded. Indeed, Barnartt (1996) asserts that the culture of disability is an identity created within a larger society; it defines the roles for individuals within that society. The members of the disabled community share a certain understanding of what it is like to have a physical impairment. They can bond over shared feelings of frustration, pain, isolation, and oppression. However, some researchers assert that what is currently occurring in the disabled community is not as much a creation of cultural identity as of collective consciousness.

According to Barnartt, (1996), a collective consciousness is, “an action-oriented set of ideas which involves notions of what is, what ought to be, and how to get there, quite unlike a social culture which equates what is with what ought to be” (pp. 5-6). The goal of the collective consciousness is not only to dissuade the notion that disability is a medical problem, but to actually alter its stereotype and make disability something to celebrate (Brown, 1995, as cited in Barnartt, 1996).

Regardless of whether the term ‘cultural identity’ or ‘collective consciousness’ is more appropriate, “Disabled people share one important attribute; they are all made the subject of oppression” (Watson, 2002, p. 512). This shared oppression though, can create a minority group, which has specific legal status. It is recognized publicly and is allowed to receive political and social power accordingly (Pope, 1984).

Wertlieb (1985) asserts that in order to claim minority status, groups must meet certain social and political requirements. First, members of the group must feel discriminated against because of a power differential within society. Second, the group is classified through a, socially important characteristic which is common to all its members (Wertlieb, 1985). However, each individual’s disability is so unique, that it is difficult to easily categorize them. It seems the only common characteristic is the shared sense of oppression. A third element of minorities is that the group must, “band together” (Wertlieb, 1985, p. 1048), and actually unite because of this shared characteristic. Fourth, membership into the minority group is usually not voluntary. This is very true for the disabled community. Regardless of whether an individual was born with a disability or becomes disabled during his or her lifetime, it is generally not a chosen path. According to Berbrier (2004), groups must fit these criteria, focus on shared ethnicity, or

compare themselves to existing minority groups to show they deserve similar status.

“Whether this acts as a categorical classification for disabled people as a social category or whether disabled people themselves identify in such a manner is not known” (Watson, 2002, p. 512).

Methodology

The Importance of Ethnographies in Disability Studies

Ethnographic studies have particular value in the field of Disability Studies because they provide longitudinal data that not only include information on specific situations at a given point, but also detail the compounded effect of living with a disability on a daily basis (Wertlieb, 1985). While cross-sectional research can be helpful in its ability to include multiple participants performing under identical conditions, it is difficult, if not impossible, to truly replicate life as a disabled person. Though some forms of physical disability may be simulated, Wertlieb (1985) asserts that the disabled deal with more than simply physical limitations; their feelings and frustrations within other sectors of their lives must be taken into consideration as well. Thus, in order to truly understand the compounding effects of disability, longitudinal studies should be conducted (Kaufert & Kaufert, 1984; Pope, 1984).

Methodology and Limitations

After breaking my ankle, I spent five weeks in a wheelchair. Although I was extremely frustrated, I decided to implement the sociological lessons I had been learning in my classes. Specifically, I chose to view my circumstances through a sociological lens. This perspective enabled me to turn my calamity into an academic opportunity in which I

could record my personal experiences in a journal, and use them as data in my ethnographic study on how the disabled people live in an able-bodied environment.

Through analysis of these journal entries, I employ a form of qualitative research known as the idiographic approach. Akin to the case study approach, this approach examines experiences from multiple individuals in order to identify patterns which emerge from the collection of experiences and to explain the potential origins of the behavior in question. Though it is important to note that the interpretability of this type of research can be considered a limitation, the idiographic approach is important because sometimes directly questioning individuals about their behavior is not always the most feasible way to collect this information. Specifically with topics such as disability or minority studies, the social desirability bias may not only prevent individuals (in this case, members of the non-disabled majority group) from stating reasons as to why they were oppressing the minority group, but could cause them to deny that they were even oppressing the group members in the first place. Consequently, though I did not question the members of the non-disabled majority group who I felt oppressed me during the time of my physical impairments, it is noteworthy to mention that even if I had, I most likely would not have gotten their true response.

With the above in mind, it is not surprising that Skar (2003) notes that while the personal insight an ethnographic study permits can be essential to understanding the lived experience, the lack of additional participants hinders the generalizability of any findings. My experiences were just that, *my* experiences, and therefore do not necessarily generalize to everyone else. However, although my views are subjective, they are based on genuine understanding. My direct knowledge of what it feels like to be disabled in an

able-bodied world gives me an insider's perspective on the accounts of others who have lived with a disability (Komardjaja, 2001). Including the experiences of others with my own allows me to maintain what Fox (2004) calls, "the delicate balance between involvement and detachment." Also, by combining multiple experiences, some of the potential bias of a single-subject case study is eliminated.

Towards this end, I analyze five studies in order to explore how the three models discussed in the above literature review play out in an individual's lived experience. These five works are by Blair (1999), Gershick and Miller (1994), Phillips (1990), Skar (2003), and Taub, McLorg, and Fanflik (2004). In addition, I narrate my own personal experiences of living with a disability and show the appropriateness, and inappropriateness, of the models of disability discussed earlier.

Discussion

Study 1 – (Skar, 2003)

In Skar's 2003 study, twelve adolescents from Sweden with limited mobility were questioned as per their relationships with their peers and with adults. Several patterns emerged throughout the teenagers' discussions that highlighted shared experiences of individuals with physical impairments. Many of the adolescents voiced the idea that their impairment did not directly affect how they identified themselves, either as an individual or with their peers. One participant stated, "I am just like all teenagers" (Skar, 2003, p. 640). This contradicts the cultural model because it shows that in the day-to-day experience, people with impairments do not always associate with or identify as part of a disabled group. They did not place their disability as their master status.

At the same time, these adolescents believed that others did judge them based solely on their impairment. While these individuals did not view themselves as part of a separate minority or sub-group, they felt their peers did see them this way. This indicates that, from the individual perspective, the adolescents with physical impairments saw their disability as a role whereas society saw disability through the cultural model of an unchangeable status. This was made clear when the participants admitted that they too saw themselves as different when in outdoor locations that have inadequate accessibility for individuals with physical impairments. When accessibility was not an issue, for example in their home, participants reported feeling just like “any other teenager” (Skar, 2003, p. 640). This shows that disability can be seen through the social model, in that when the environment allowed, the teens could do everything as others could, and they saw themselves as the same. It was only when barriers in the environment set him apart was he put at a disadvantage and became disabled.

Research showed that compared to able-bodied teenagers in this time and location, the physically impaired adolescents in this study seemed to be included in social activities less often. Also, their physical impairment restricted their ability to spontaneously participate in activities with others. Many stated that they participated in fewer activities with their peers either because the event was in an arena they could not attend due to accessibility or they felt stigmatized/stereotyped by their peers. This indicates that social as well as physical barriers can greatly affect how an individual with a physical impairment fares in the environment.

Outside of the classroom, it seems that the students with physical impairments felt extremely isolated from the rest of the student body. The disabled students thought this

lack of close friendships was due to their prolonged inability to engage in social events with others, often creating a rift between students when childhood bonding activities occurred. In order to make friends with other students, the disabled students were required to initiate interactions. One participant stated, "I was always the one who was seen as different because I was the one who couldn't take part" (Skar, 2003, p. 643). These experiences indicate that the disabled students were set aside because they were seen as different, even though the only reason they were different was because the environment prevented them from functioning properly. While the social model should generally allow for individuals to take on the role of disabled depending on the environment, society tends to trap disabled individuals into the disabled role. Members of society latched onto this label and applied it all the time, not just when the environment did not fit, thus putting the disabled students into the minority group and making it more difficult for them to connect and make friends.

Most of the participants also discussed this idea of social barriers during their interviews, giving evidence for the existence of non-physical barriers to accessibility. The students believed that their social interactions were difficult because their peers saw them as being different than the other students. The teasing they endured from other children at school often prevented them from making friends. As a result, many of the adolescents felt the need to learn to make fun of themselves and become the class clown as a way to make their impairment appear less visible (Skar, 2003). It seems as though the teenagers were overcoming their role as disabled by over exaggerating their role as a jokester.

Participants' relationships to their parents were also conflicted. Often they reported feeling close to their parents and yet dependent. This dependency led the students to feel that their parents were serving as, "obstacles to their attainment of independence" (Skar, 2003, p. 642). The participants reported feeling grateful for the help but frustrated by the restraint it put on their lives. They felt controlled by their parents' expectations of them, and felt they possessed little autonomy when it came to choosing social roles. Such feelings of ambivalence are not unusual for individuals who constantly cycle through feeling "normal" and feeling "disabled."

Study 2 – (Blair, 1999)

Blair (1999) was involved in an accident at the age of 23, which left him temporarily paralyzed. Through rehabilitation, he regained the ability to walk but with aids such as braces and a cane. In his article, he discusses his experience and his feelings about his disabled body. He describes in detail his initial hatred of who he had become. He realized, for the first time, that he held many negative attitudes against people with physical impairments and he felt these attitudes of other people. Essentially, he was looking at people through the medical model and used that to group them into a cultural minority with all of its stigma and discrimination. And, although he was now a part of that group, he still saw disability as a cultural minority and held a stigma against this group. He felt other people viewed him this way, too. He describes people's reactions to him as either disgust or pity. "It was uncomfortable but this was reality," he stated (Blair, 1999, p. 9). The author discovered that he, as well as others in society, defined him by his ability to function and that he was now less valuable than others because he could not walk. He questioned, "Who was I and what value did I have without the use of my legs?"

(Blair, 1999, p. 9). He recorded often feeling shunned and degraded by others because of his disability. He realized that within the framework of the medical model, people defined him by his physiological state, and upon determining that he was damaged in some way, placed him in at a disabled minority status.

The author articulately states,

Struggling to fit in, I wanted only to be normal, yet felt so different. Walking, such a simple and effortless task for others, was nearly impossible for me. I felt my disability would forever mark me as an outsider. It was the first thing others saw. And once seen, many wanted to look no further. Nearly all students were nice to me and offered to carry my books and help me in other ways, yet I never felt like an equal. They did for me rather than with me. Even when I did not need help, they helped me. Although I was slowly becoming more self-accepting, the way most students treated me made me think that I was perceived as damaged goods. This reinforced old prejudices and made me wonder if I were, in fact, of less value because of my disability. (Blair, 1999, p. 11)

He remembers over time becoming more accepting of his physical limitations, yet. Eventually, he realized he was more than just this one identity and wanted to be seen as an individual and not just as a part of this minority group. He also recognized that he was only disabled when the environment caused him to be. However, within social settings, his impairment was a part of himself that he refused to include in his overall identity. He hardly ever spoke about being disabled with either professors at his university or his peers. The young man was still aware though of the stigma that others had against individuals with physical impairments. “Judgment by others was almost

always subtle, but I would notice actions and expressions that indicated to me that my physical flaws eclipsed all of my other attributes” (Blair, 1999, p. 12). This indicates that society was placing the author’s disability as his master status. He began to understand that others may not even realize what he was or was not capable of. In one situation he describes being told to sit down while someone else would get his lunch for him. The author was furious at being told that he could not do something that he knew he could. Another time, a friend told him that he did not see him as disabled because he did not “act disabled” (Blair, 1999, p. 12). The author stated that he did not even know what it meant to act disabled but wished to teach people that an individual with a physical impairment can act just like anyone else. He realized that, though he did not view disability as his master status, others still saw him as part of the disabled minority group. Even if closer friends did not place him specifically into the group, they saw people with disabilities as a group, one with definite stigmas and stereotypes. They held certain expectations of individuals within this group; expectations that often over-exaggerated their disability.

He eventually came to the understanding within himself that he was more than his disability. He strongly believes “that whatever our minority or majority status, we are individuals first and unique abilities and talents...In addressing minority populations, including those with disabilities, I emphasize the “strengths” perspective and believe that it better serves those of minority status than does the traditional medical model” (Blair, 1999, p. 13). He also asserts that even with ADA regulations lowering environmental barriers for the disabled, to fully integrate them into society as ‘normal humans,’ the social barriers that he encountered will have to be addressed and broken as well (Blair,

1999). Ideally, he would like society to see disabled people as individuals, to look beyond a cultural group and see them for the unique people they are.

Study 3 - (Taub et al., 2004)

Taub and colleagues (2004) used taped interviews to investigate the experience of women with physical disabilities in an academic setting. Though the twenty-four participants had a variety of ailments including but not limited to the use of a wheelchair, braces, a cane, and even a guide dog, many of the participants described similar experiences at their university. “The vast majority of responses reflect a college environment that is considered ‘chilly’ and unwelcoming” (Taub et al., 2004, p. 172). These women felt defined by their disability and looked down upon because of it. Because they had an impairment, others immediately saw the women as disabled and held certain ideas and stigmas against them only because they are a part of this minority group.

Most of the participants did not personally emphasize their belonging to a disability minority while interacting with professors or peers; in fact, many tried to emphasize their abilities to do things, both academically and physically. These women were attempting to disprove the inaccurate assumptions believed about members of this minority group by showing that individually, they were just as able as most of their peers in many situations. Despite these efforts, many stated that, “faculty sometimes treat students with physical disabilities as if they are not capable of completing academic responsibilities” (Taub et al., 2004, p. 178). However, when participants asked for professors or others at the university to accommodate their needs, they felt as if they had to ‘prove’ their disability in order to get their needs met. These women refused to be

excluded from campus activities because of their disability. When the students felt they were somehow prevented from accessing academic and social objectives, they were forced to assert their differences in order to receive equal accessibility. “These women claim a disability status to improve their success as students with physical disabilities” (Taub et al., 2004, p. 179). In these instances, the students tried to embrace their minority status in an attempt to break down barriers to accessibility, thus giving them the chance to relinquish the role of disability. However, by ascribing to this minority status, the women found that others then assigned this as their master status, one that cannot so easily be relinquished.

In addition, many of the respondents also dealt with the stigma they felt on campus by providing information about their disability in order to reduce inappropriate beliefs and stigmas. Others used the strategy of deflection in which they “attempt to reduce the salience of the stigmatizing attribute by accentuating other aspects of themselves (Goffman, 1963). The intent is to shift attention from the attribute and focus on other, socially valued aspects of the individual” (Taub et al., 2004, p. 175). Others tried to normalize their impairment by making it a non-issue; however many of the participants stated that despite their attempts, others still identified them only by their disability. Finally, several of the women advocated equal accessibility for the disabled. However, “without the opportunity to exchange similar experiences and struggles, these women lack ‘one of the powers of minority group recognition’” (Deegan, 1985 as cited in Taub et al., 2004, p. 188), and thus felt alone in their experiences.

Study 4 – (Phillips, 1990)

In 1990, Phillips interviewed thirty-three university students who frequently interacted with other disabled individuals and had participated in disability activism. Nineteen of the participants have had a physical impairment since birth; the remaining acquired one through illness or injury. Each of the participants was interviewed separately in an informal manner.

Though many participants discussed different aspects of their disability that was pertinent to them, several themes emerged from the responses in regard to social interactions. First, many participants discussed in some way the idea, “that society perceives disabled persons to be damaged, defective and less socially marketable than non-disabled persons” (Phillips, 1990, p. 850) a clear description of the medical model; second, they proposed the idea that society thinks people with disabilities should work harder to succeed and achieve normality than non-disabled individuals; and finally, the idea that society wanted them to interact mostly with “their own kind” (Phillips, 1990, p. 853) was brought up. This study shows another way that people get stuck in a culture because society classifies all people with impairments in the same group and holds them to the same standards.

Many of the participants commented that society made them feel ‘damaged’ in some way, a common theme under the medical model, and that because of their disability they were not as good as other people. Some attributed this connotation to society’s emphasis on perfection. One participant felt that both images in the media and the language used with disability could actually reinforce the negative stereotype placed on people with physical impairments. She specifically stated, “That’s why I don’t like the

dis in disabled” (Phillips, 1990, p. 851). This participant knew that she was often able to function as well as her peers and was therefore not always disabled.

The participants in this study all came from a midwestern town in the United States, thus they have all experienced growing up in the larger cultural framework of the American work ethic. Several of the participants claimed that this added to the negativity they encountered. They felt that society sees them as unable to contribute to the work force and thus worthless. Even after obtaining a job, one informant believed that people he worked with who knew him well still saw him as less than capable. Though the student stated his ability to perform the functions of the job, his co-workers seemed unwilling to acknowledge this ability. Many of the informants felt that others saw them as incapable, regardless of the closeness of the friendships.

The participants in this study also commented on their interactions with peers. As children, most recalled stories of being taunted by their peers because of their physical impairments. Many even felt pressure from family members to conceal their impairment (Phillips, 1990), thus adding to the belief that there really is something ‘wrong’ with them. One participant seemed to internalize this idea, and though deaf herself, refused to associate with other deaf individuals. Specifically, “Susan’s version of the American Dream is that her perseverance to appear normal will obscure her disability” (Phillips, 1990, p. 853). The participants also felt that many of their social interactions were wrought with feelings of helplessness. They stated that the people they dealt with treated them as if they always needed help and that these non-disabled people would be able to help them function better.

The informants in this study shared quite a few patterns of beliefs about society's views of them. They spoke of the media's ability to enhance the spread of the negative stereotype of disability. Though they themselves did not feel damaged, the participants felt society viewed them as such, clearly showing a distinction between the way individuals with physical impairments define disability and the way society in general does.

Study 5 – (Gershick & Miller, 1994)

Gershick and Miller (1994) interviewed several men with physical impairments in regards to their relationships with their peers. The informants felt that these relationships were extremely important in defining who they are. As one informant describes, "I think it [others' conceptions of what defines a man] is very important because if they don't think of you as one, it is hard to think of yourself as one or it doesn't really matter if you think of yourself as one if no one else does" (Gershick, & Miller, 1994, p. 41). This participant goes on to describe the idea that regardless of how he saw himself in terms of his gender or disability, society at large was going to define him the way that they wanted to and this, in turn, affects the way he sees himself. Regardless of where he puts himself in the cycle of the social model (disabled or not disabled), society was going to classify him as disabled and put him in that minority group. As this relates to his impairment, even if he chooses to ignore it, if everyone else in society defines him by his impairment, then that is what he is seen as by others. Another participant reiterated this idea, but adamantly refused to let society define him. He continued to define himself as "as a 'person first.' In this way, his humanity takes precedence and his gender and his disability become less significant" (Gershick & Miller, 1994, p. 49).

Most of the participants also shared what it was like to interact with their peers as both a man, a role that expects the individual to be strong and dependent, and as a person with a physical impairment. One participant stated bluntly, “no one... can be prepared for a permanent disability” (Gershick & Miller, 1994, p. 42). He was not ready to deal with the idea of feeling vulnerable and weak compared to his peers. Another participant explained that these were the expectations his friends had of him after he became disabled. Though he was still a man as well, the disability became his master status and his peers seemed to see him only as his physical impairment. He stated that his peers continued to, “socialize with him as long as he remains in a dependent position where they can ‘help’ him” (Gershick & Miller, 1994, p. 41). In response, the participant tended to exercise his autonomy as much as possible and refused to ask for help in most situations, thus showing that they are not always disabled. (Gershick & Miller, 1994) As seen in interview responses from other studies, some of the participants even internalized society’s negative views for themselves. One participant, a former athlete, refused to participate in sports for individuals in a wheelchair, and stated that he wanted to be a “real athlete” (Gershick & Miller, 1994, p. 45) once more. Not only was society telling him that because of his impairment, he was not a real person, but this informant was telling himself that.

Study 6 – My own experiences

I first experienced what it means to be ‘disabled’ when I broke my ankle during the second week of my senior year in college. Falling on the stairs of the two-story house I lived in caused a bilateral break in my left ankle, a serious enough injury to require surgery that evening. Because of the nature of the break and the process needed to

recover, I spent the next five weeks in a wheelchair. My living arrangement, a bedroom on the second floor of the small home, obviously did not accommodate the situation. Fortunately, the university I attend has a few wheelchair accessible dorms and they immediately moved me into an empty room in one of those buildings.

As my parents moved my belongings into my new room, the girls on the floor all inquired about their new neighbor. They seemed sympathetic after learning of my accident and looked forward to meeting me when I arrived the following weekend. However, I was not greeted with the type of empathy and understanding that I expected given the way they had talked with my parents.

I felt very much the social outcast. Many of them rarely, if ever, spoke to me. The few who did found it hard to even look me in the eye. Granted, my eye level was near their waists, but they often looked directly over me, making me feel completely invisible or they looked only at the wheelchair. I very often felt invisible as a human being and conspicuous as a large rolling object simultaneously. The hallways of this dorm were also quite narrow, forcing me to take up the whole space as I wheeled from my room to either the bathroom or the elevator. Although I quickly learned to maneuver myself around and became very adept at it, if I approached another person in the hallway, they often rolled their eyes at me or showed annoyance through their body language at having to wait for me to go by.

The bathroom situation alone was a huge ordeal within itself. The floor I was living on was in accordance with the ADA standards in that it contained a wheelchair accessible toilet stall, sink and shower. However, the girls, although completely aware of the fact that there was someone living on the floor who actually required these facilities

and could use only these facilities, used that stall and that shower all the time. Almost every day, I would have to sit in the middle of the bathroom next to three open showers as I waited for the one girl using the handicap shower to finish. Upon exiting, they often ignored me or smiled and went on their way not even realizing that they were holding me and that I could not simply use another shower stall.

The doors to the bathroom were also an issue. They were heavy doors and did not have handles; they simply swung inward with a push. This was difficult for me as I was forced to push and hold open the door while maneuvering my wheelchair through the doorway. I found a way to prop the door so that it was always open and I was free to enter and exit the bathroom with ease. I felt less restrained and less obviously disabled being able to perform all these tasks just as well as anyone else. Even though, with the bathroom door open, the only area visible from the hallway was the sinks, the girls refused to leave the door propped. Thus, I often struggled with the door on my own. Many times if another resident was entering the restroom at the same time as me, she would hold the door for me. While I appreciated the help, it made me more aware of my inability or 'dis'-ability to perform such a simple task myself. If, as I entered the bathroom alone, there was already a girl standing at the sinks, she would just watch me struggle to enter and say or do nothing. This too, left me feeling annoyed in that she would not help someone with a difficult task.

I often had these ambivalent feelings with receiving help from others. A prime example was going to my classes everyday. All three of my classes were located in a building just up the hill from my dorm. Though I could manage to push myself up this hill, it took quite a bit of strength and I did not keep up the speed of my able-bodied peers

who could walk. A few times a considerate stranger would offer me a hand and push my wheelchair. I was grateful for the break, as were my muscles. However, this experience also pushed me, from my perspective, into the center of attention, showing everyone else on the sidewalk that I was not able to get up the hill myself, thus calling attention to my wheelchair and my disability. It was only when it was obvious to others that I could not do something for myself that I become aware of my different-ness and it was only at these times that I labeled myself 'disabled' as opposed to injured or some other less stigmatizing word.

Upon arriving at the entryway to the building in which my classes were held, I was grateful to find that it too was wheelchair accessible, including both an elevator and buttons on each side of the doorways that electronically opened the door for me. I could push this button and not even have to worry about holding the door as I wheeled myself through. The problem I encountered with such doorways though was that the lip of the doorframe was so tall that it was difficult to get the smaller front wheel on my wheelchair over it. I learned to turn myself around and wheel in backwards once the door had opened. I was proud that I could do this activity for myself, but again I knew that turning myself around in front of the doorway was conspicuous and it drew the attention of others to the fact that I was disabled.

The university did help me out though by moving all the classes I was enrolled in to different rooms, rooms located within this easily accessible building. Two of my classes were in fact originally located in buildings that could not be accessed with a wheelchair. There were not ramps outside the building, not that ramps would help anyway since once inside, there were no elevators to the upper floors. The university was

extremely accommodating to my needs in this way, but everyone in my classes was aware of the fact that we were moving rooms because of me and my inability to meet in the assigned classroom. In one of the new classrooms, there were no tables; it was actually a large lecture hall that contained only seats with attached side tables. As such, I was forced to sit in the front of the room on the end of the first row and write in a notebook on my lap since there was nowhere else for me to go. Again, I could get myself into this room and I was just as able as any other student to attend class and participate in the class activities, but I was acutely aware of my disability in this setting because it was obvious to everyone else that I had to perform tasks differently than they did because I was in a wheelchair. In a classroom in which I was able to wheel directly up to a table, I, along with my peers, forgot that I was sitting in a wheelchair because I could function just as well as they could in this setting. These classmates rarely saw me, or at least rarely treated me, as if I was 'disabled.'

Like the university in general, my professors were very understanding as to my different needs and helped me through this time. However, I felt that some professors singled me out in ways that they would not have had I not been in a wheelchair. For example, if the professor was calling out students' names to have them come to the front of the room to pick up paperwork, he would stand in the front and just give the papers to the students as they approached him. With me, on the other hand, he would make a big deal about walking over to me to hand me my papers where I sat. I knew that I could just as easily wheel over to where he stood and receive my papers like anyone else, but he never gave me that chance. It was as if he underestimated my abilities to do things by

overestimating the degree of my disability, which actually made me feel more disabled, or more likely to take on the role of the disabled, in this situation.

Not everyone I encountered in the community was as accommodating as my professors and administrators at the university. I often felt looked down upon because I was in a wheelchair and people carried certain beliefs about what that meant about me and how they felt in interacting with me. Some of the harshest comments were made about me by my peers who held false beliefs about people in wheelchairs. Rumors were circulating within one particular group of people that I was in a wheelchair only for sympathy. They saw it as a way for me to get attention and that it wasn't actually necessary given my situation. This was hard for me to hear because it made me feel that perhaps I did not need to be in a wheelchair. Though I better understood my situation and knew that it was necessary, it really put me on the spot and almost had me defending my disability and forcing me to explain my limitations to strangers. I felt as if I had to take on the role and force people to understand it before they could forget about it and see me for who I was and not how I got around.

Other people completely misunderstood the pervasiveness of my limitations and expected me to do things that simply were not possible. One night the fire drill went off in my building. Not sure what to do since the elevator shuts down when the fire alarm is ringing, I slightly panicked. As I left my room and headed to the hallway, I remembered that the adjoining building is protected by fire doors and setting off the alarm in one building does not set off the other. I headed over to the connecting hallway to cross over, a practice that is actually prohibited. I sat in the adjacent building, slightly annoyed but content to wait until the fire department turned off the alarm and let everyone back into

the building. While I sat there, however, a Resident Assistant of the building I did not live in approached me. Knowing that I belonged in the building that had been evacuated, she actually began to scold me for breaking the rule by crossing over during a fire alarm. I asked her what she expected me to do given that I was in a wheelchair and by the time the alarm had gone off it was too late for me to exit, save sliding down the stairs on my backside. She finally began to understand the ways in which I was limited and that although I was breaking a rule, it was the most logical thing for me to do during a fire alarm, especially given the frequency of false alarms in the hall anyway.

There were other times I noticed that being in a wheelchair prohibited me from doing certain things and going certain places. Before my disabling accident, I had obtained VIP tickets to a show in a large auditorium which guaranteed me seats in the first few rows. However, once I arrived, they informed me that wheelchair seating was near the back of the auditorium and that I could not sit in my ticketed seat. On top of that, the wheelchair seating area on the first floor was already filled and they sent me up to the balcony to be seated. I ended up sitting in an alcove off of the walkway that was directly in front of the first row of seats. The people behind us become obviously annoyed that someone in a wheelchair was sitting right there even though that was what the area was designated for. Both attendants and staff acted as if I was in the way sitting there because I was halfway into the aisle. I almost felt guilty for putting all of these people out, and that I was in people's way because I was in a wheelchair. People tended to act annoyed when I got in their way but they also never looked at me directly. I felt as if I was completely invisible and an annoyance to people at the same time. I honestly remember guilt being the prime emotion that night, as if it was my fault for being different from

other people. I definitely felt the stigma that being in a wheelchair carried and that night I was extremely aware of my disability, even though I was just sitting watching the show like everyone else.

Attending social events such as this one was not a common occurrence during the six weeks I was in a wheelchair. In fact, going anywhere and doing anything was a huge ordeal and often had to be planned far in advance. My life at this time definitely lacked spontaneity. Friends would ask me to attend an event at the student center or go out to dinner with them and I would have to decline because I would not be able to get in my wheelchair, collect my belongings, get out of the building and wheel myself to the event's location before it started. In addition, the idea of going through all that hassle was not worth going to the activity. At other times, I felt left out of activities because it would not be feasible to have the wheelchair there. Thus, being in a wheelchair at this point made me unable to do certain things, leading to the feeling of being disabled. When an activity was taking place in an area that I could maneuver my wheelchair, I went without a second thought.

Parking was a frustration in and of itself. Getting into the wheelchair from the car seat was difficult enough, but trying to wheel myself through the parking lot with cars moving everywhere was a dangerous situation. It was nice to be able to park in the spots closest to the door so that I could wheel directly into the building without dealing with the parking lot traffic. Many times though, the "handicap" parking spots on campus would be taken by cars that did not have a permit hanging in the window or a sticker on the license plate. One day when I desperately needed the spot and someone was thoughtlessly parked there, I called the university security to ask them to help me out.

Though they often write parking tickets for illegally parked cars, they told me there was nothing they could do. I was infuriated. I felt as if they were telling me I was undeserving of a designated parking spot; I felt as if they were questioning the severity of my impairment. Ironically, this questioning threw me into embracing my impairment and taking on the role of a disabled person more emphatically.

Once out of the wheelchair I still required the use of crutches or a brace on my leg for a number of weeks in order to walk. Even though I could see the progress I was making through physical therapy, others still saw me as having a disability. For me, being out of the wheelchair was a huge step to no longer labeling myself 'disabled.' However, I soon realized that one could not drop that identity so abruptly and that it was still dependent on my immediate environment. For example, one day a few friends took me bowling to celebrate my independence from both the wheelchair and crutches. I was still wearing a fairly sturdy ankle brace inside my shoe. It was difficult for me to bowl correctly because of the way I needed to move my ankle and the brace not allowing me to do so. I felt restricted and unable to do something I thought I should be able to do. I was quickly frustrated by once more being limited in mobility, as I no longer saw myself as disabled.

Finally, one of the most glaring representations of how others saw me came on a day I no longer had any visible impairment. Although I still walked with a visible limp, no crutch or wheelchair was in sight. I was standing on the elevator of my building waiting to go up to my room, as stairs were still a major hurdle to overcome in my physical therapy sessions. A girl in my building, whom I did not know but who had apparently seen me around in my wheelchair previously, recognized me and realized that

I was standing on my own. She said, “Hey, you’re out of your wheelchair.” I smiled and told her I was and that I only used a small brace now to get around, lifting up the hem of pants to show her. She responded, “You’re almost like a real person again.” My heart sank and my jaw dropped. During my five week ordeal I knew I was different, I sometimes even identified myself as disabled; I never realized though that I wasn’t even seen as human.

Being in a wheelchair made me different than someone else, but I could do what they did. My environment prohibited from doing certain things at all; that made me disabled. My peers saw me as ‘not a real person;’ that was degrading.

Conclusion

Views of Disability

“Disability identity is important, as Shakespeare (1996) argues, because it is through identity that an understanding of the complex relationship between individuals, society and biology emerge” (Watson, 2002, p. 513). The descriptive results of this study show that many people who have lived with a disability, including myself, consider disability to be a role rather than a cultural minority. Not all people with physical impairments are the same. They do not have the same experiences and do not identify the same way, aside from the oppression and stigma they feel from the majority, able-bodied, group.

Even though individuals may be unable to relinquish their impairments, they can choose to relinquish the role of disabled so long as the environment allows. Because their impairments become problematic only when the environment fails to fit their needs, these individuals consider themselves “normal” most of the time. When they feel in

some way incapacitated by physical or social barriers, these individuals become people with disabilities. However, society does not appear to think people can relinquish such roles, and holds them to a fixed status and attaches a negative stigma. The oppression caused by this creates a disability minority group. A rift occurs because many people with disabilities do not want to be seen as a minority group, but as individuals. In order to bring about change though, minority status must often times be recognized and cannot be renounced. However, regardless of whether these people desire to be part of the minority, society at large categorizes them as a lower class, a group of “helpless” citizens.

As stated, it is only when their environment establishes a situation which makes them unable to perform a certain task do these people become disabled. But in order to lose this role, the environment must be altered. However, those with the ability to make such a change are rarely willing or able to respond to individual complaints, to listen to one voice. Only when the power of that individual issue grows by having a group of people demanding change does anything even start to happen. Though minority groups may have little power, they have more power than any individual person would have alone. Often, it is harder to receive public funding or change the environment when individuals are not part of a recognized minority. In order to receive funding, change the physical environment, earn equal status, or decrease or eliminate oppression and stigma, people with disabilities often need to be seen as a minority group.

Because “minority” implies stigmatization, many individuals with disabilities are uninterested in becoming an active part in this group. Instead of ascribing to a specific disability culture, many of the disabled choose to take on the role of a person with a

disability when something in the environment creates a situation in which they are unable to perform a task. Once the environment is altered to become accessible, they no longer take on the disabled role because the environment no longer places emphasis on their disability. According to Watson (2002), even when the environment constrains the abilities of the disabled, they do not allow their impairment to define them. In the day-to-day reality of living with a disability, people do not identify as a part of a larger group. They simply see themselves as individuals, as being unique like everyone else, not like everyone else with a disability. They do not define themselves as disabled. These individuals refuse to let their disability serve as their main identity. They do not see themselves as a minority group, only different in the way that people with glasses or shorter legs are not disabled, but different.

In summary, people with disabilities cycle between whether or not they take on the role of disabled. According to the medical model, people with disabilities should want to return to a “healthy” state by dropping the sick-role. Within the social model, individuals do seem to relinquish the sick role as long as their immediate environment allows. When the environment allows, these individuals feel “normal,” and interact like everyone else. They still have physical impairments, but do not feel significantly affected by them and do not consider themselves to be part of the disabled minority. When the environment does not fit the needs of people with impairments, the impairment becomes a disability within that environment. Once again, they have taken on the sick role because they cannot function as well as a ‘healthy’ individual. As soon as the environment is altered to fit their needs, the sick role is dropped and the cycle continues.

However, regardless of whether or not the disabled view themselves as participating in this cycle or as a minority group, society generally sees them as a minority group and defines disability as a status that is unable to be relinquished or changed. Before I broke my ankle, people saw me as a unique individual, but basically no different from themselves. After I broke my ankle, people saw me as disabled. Even when I could get around without a wheelchair or crutches, people treated me as if I was still broken or disabled. They refused to let me return to my previous status, even though I had quite obviously given up my sick-role. While I held up my end of Parsons' bargain, desiring to be "healthy" again, seeking all available medical aid, and not taking advantage of any benefits I might have received, society failed to fulfill their end. I was still seen as disabled and treated accordingly. Essentially, the common experience of people with disabilities is to take on and relinquish the sick-role as the environment allows regardless of the permanence of their impairment. The debate is not over the existence of a physical impairment, but over what that physical impairment means in the context of a role the individual takes on.

Costs and Benefits of Minority Status

Declaring one's own minority status has both costs and benefits, and therefore making the decision to ascribe to a particular minority group can be a difficult one. Nevertheless, an intrinsic problem exists even in just the creation of minority groups. In order to claim minority status, a group must assert its uniqueness from the more powerful majority. The group does so, however, with the intention of demonstrating to this majority that the individual members of this group are in fact no different from the members of the majority (Galvin, 2003). In order to be considered a minority group in

the eyes of those who have the ability to exert change, group members must state how they are different from members of a majority group. However, part of the reason a minority group is formed is to seek justice for its members and to end discrimination and oppression by asserting how normal they really are.

While the disabled community can be viewed as a minority, the disabled cannot be classified quite as simplistically as members of other minority groups. Such groups can be classified based on characteristics possessed by all group members, characteristics that are visibly evident and most often have no bearing on the members' ability to function (Kaufman-Scarborough, 2001). Disability takes on both visible and invisible forms and may or may not actually affect an individual's ability to perform certain functions depending on the task at hand.

Berbrier (2004) states that minority groups often desire to be seen as 'normal' and want to be proud, rather than ashamed, of their unique qualities. However, while other minorities learn to find pride in what makes them different from the majority, this is not true with disabilities (Wertlieb, 1985). Specifically, "The traditional reversing of the stigma will not so easily provide a basis for a common positive identity (i.e., disability is beautiful, up with MS, long live cancer, don't you wish you were blind, etc.)" (Zola, 1993, p. 168). By focusing on the minority group itself, members feel legitimized as a group and as individuals, leading to feelings of normalcy and an increased sense of self-worth (Berbrier, 2004).

Also, while most members of minority groups share their experience with others through frequent interactions, thus creating at least a sub-culture, people with disabilities often have no such cohort. Instead, they must each individually face their own traumas

and setbacks. Even family and friends, who share minority status within other minority groups, cannot relate to the disabled individual (Zola, 1993; Best, 1967, as cited in Wertlieb, 1985). Therefore, the minority of disability can often feel like a minority of one, an isolating experience for the impaired individual.

Though size neither automatically grants nor denies a group minority status, larger groups with more political or public clout generally have stronger abilities to claim such a label (Berbrier, 2004). By achieving social and political status as a minority group, members receive a sense of legal existence which may safeguard them from further discrimination (Berbrier, 2004). The “us versus them” concept drives individuals to group membership, even if the individuals in question do not want to declare an association to this group. This is a particular problem for people with physical impairments because each disability is so person- rather than group-specific. Even if someone with a disability prefers not to be grouped with other disabled people, society may automatically group them because of the difference people think a physical impairment implies.

While minority status allows individuals with disabilities to connect with one another over shared feelings of oppression and loneliness, and therefore breaks some of the isolation, it does so at what cost? (Galvin, 2003).

If creating a sense of group affiliation between disabled people based on the collective notion of a ‘disabled identity’ is such a positive and empowering practice, why then do so many of the people who can be said to be disabled according to the social model, that is, those who have impairments or illness that

lead to their social exclusion, choose not to identify themselves as such. (Galvin, 2003, p. 676)

While becoming a minority group does have benefits, individuals often become anonymous in order to become a group. “The disabled are generally evaluated in terms of group membership. Special skills and abilities are only secondary traits as opposed to the specific disability. Whether a blind person is a doctor or lawyer, he or she is considered primarily a ‘blind’ doctor, a ‘blind’ lawyer, etc.” (Safilios-Rothschild, 1970, as cited in Wertlieb, 1985, p. 1053). This may take away from any specific pain or suffering an individual has in his or her own life. Though being a member of a minority may provide individuals with necessary environmental and social change, it also has a weak or outsider connotation (Berbrier, 2004).

Implications

Policy Issues. How disability is labeled is important because of the implications associated with different terms. Because government funding is determined in part by label, Zola (1993) argues that, “The disabled movement has purchased political visibility at the price of physical invisibility” (p. 170). In order to better achieve their social and political goals, individuals form minority groups. By doing so, they have increased access to local and national funds, and can legally prevent others from discriminating against members of the minority group.

From society’s standpoint, disability consists of a variety of physical and social accessibility issues (Pope, 1984). Policymakers need to extend their understanding of a barrier beyond simply physical and into social and economic connotations as well (Wertlieb, 1985; Kaufman-Scarborough, 2001). Just as disability is a continuum, so is

the concept of accommodations which must be made. While it may seem more comprehensible to conquer a barrier in the physical environment, it is far more difficult to envision a change in the social environment (Komardjaja, 2001). The oppression and stigma related to the disabled minority exist because of a lack of awareness and understanding.

Language. It seems clear from these results that how disability is labeled also plays a large role in how people with disabilities feel about themselves within a larger society. The term “disabled” implies that the physically impaired are not as able as others to function in some given capacity. “Differently-abled” suggests that the physically impaired are just as able as others, so if they are unable to function in specific circumstances, it is society’s fault. Society is disadvantaging them because the environment fails to meet their needs. Everyone is differently-abled because everyone has a different ability to function. A child who is unable to properly throw a ball or compute a mathematics calculation is not considered disabled, that child simply is not as able to perform these tasks at the same level as other children. When people perform above the average expectation, they are considered to be “gifted” in that area. Such a label does not take ability away from others, but shows exceptional talent for certain individuals. Thinking beyond simply ‘what’ we call things to the ‘why’ we call things what we do is vital. “What is needed is not so much a change in language as an awareness of the power of words to condition attitudes” (Zola, 1993, p.167). Society needs to make a move away from simply politically correct terminology and towards politically correct thinking.

Zola (1993) cited a poem by Nancy Mairs entitled, “On Being a Cripple.” The poem is as follows:

First, the matter of semantics, I am a cripple. I choose this word to name me. I choose from among several possibilities, the most common of which are handicapped and disabled. I made the choice a number of years ago, without thinking, unaware of my motives for doing so. Even now, I’m not sure what those motives are, but I recognize that they are complex and not entirely flattering. People – crippled or not – wince at the word cripple, as they do not at handicapped or disabled. Perhaps I want them to wince. I want them to see me as a tough customer, one to whom the fates/god/viruses have not been kind, but who can face the brutal truth of her existence squarely. As a cripple, I swagger. (p. 169)

This is simply one example of how labels can affect, positively or negatively, someone’s self-image. Words can take on different meanings in different circumstances for different people (Corker, 1999). However, word choice is important when referring to people with disabilities. Depending on what is said, the disability can be emphasized more or less than the person themselves (Zola, 1993). Specifically, “The difference between ‘being confined to a wheelchair’ and ‘using’ one is a difference not only of terminology but also of control” (Zola, 1993, p. 170).

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