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**“Applying a social model perspective to the lives of  
blind ex-servicemen”.**

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**“Applying a Social Model Perspective to the Lives of Blind Ex-Servicemen”**

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## Chapter 1 - Introduction

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“To be blind may mean to be helpless, incompetent, perpetually resigned to a life of dull ineptitude. To be blind may mean to carry on one’s life almost as before, to put up with minor inconvenience in conquering problems as they present themselves. Lots of people see without perceiving, blind people learn to perceive without seeing.”

This quote comes from Sir Arthur Pearson the founder of the charity, St Dunstan’s, for war-blinded servicemen. Pearson himself became blind (through glaucoma) at the beginning of the second World War. He became determined to use his business acumen for the benefit of other sight-impaired people and joined the Council of the, then, National Institute for the Blind. Shortly after he was made aware of the servicemen returning from the front with injuries resulting in sight loss and he focused his energies on setting up a hostel for the rehabilitation and vocational training of these soldiers (Castleton 1990)

The purpose of this study is to examine the experiences of servicemen returning from conflicts throughout recent history; the Falklands, Northern Ireland and the first Gulf War – through the tenets of the medical and social

models of disability and to attempt to gauge what impact, if any, has been made by the social model approach to notions of self and identity.

Since 1980 I have worked with blind and partially people as Technical Officer, Mobility Officer (with Social Services) and Area Welfare Officer (with St Dunstan's). The work I undertook was aimed at maximising the independence of blind people but was placed within the financial strictures of local government and so could be described as service-led while the charity work was based upon the historical notions of what was needed. My experience of disability is therefore secondary being one step removed from the personal.

The main data source for this study will come from interviews held between 6 ex-servicemen and myself. Because of the fact that I have already had a role within the lives of these men for the last six years, a relationship already exists that will make it easier both for me to ask questions regarding their personal experiences and for the participants to answer freely. An important consideration will be their right to remain anonymous and have their trust repaid by the utmost confidentiality. Therefore, each participant will be given a consent form that agrees to their full participation on the understanding that their wishes regarding confidentiality will be respected.

The servicemen will be chosen to reflect experiences in conflicts spanning 30 years through the Falklands War, the Gulf War and Northern Ireland. Even though they may have no knowledge of the medical and social models of disability, it should be possible to chart any impact from the social model theory of disability on the variations in their experiences. Those experiences encompass daily social interaction and employment. Does the fact that we no longer have blind ex-servicemen standing on street corners selling matches mean society has made progress in understanding its disabling nature or is oppression merely practiced in a different manner?

It may be ideal to interview these people beforehand to prepare the ground with a description of the social model and an explanation of the hypothesis of this research. However, that may well be costly in time and not feasible. It will therefore be very important to get the questions right so that the data produced is relevant to this study. The questions will, broadly speaking, focus on the particular history of each participant, looking at their lives, hopes and expectations prior to the incident that caused their sight loss and evaluating how those aspirations changed. More detail on the actual questions used can be found in the chapter on Methodology but the general areas covered will be notions of self and identity, citizenship,

employment, peer support and the provision from statutory and voluntary organisations.

In the second chapter I will be looking at various literature relevant to this study. Included in this will be work on the medical and social models, identifying their strengths and weaknesses in relating to the adjustment to be made to a 'disabled' identity both generally and also specifically to sight loss. There will also be reference to the differing theories on how 'identity' is realised and what contributes to this process, so that in a later chapter of this study this can be equated to the life-histories of the participants.

This study will also encompass the rights bestowed upon disabled people through the Disability Discrimination Act and the Human Rights Act, balancing law against actual provision by statutory and voluntary organisations. Does what is legally required match provision and do the services provided make our society less disabling?

The three central chapters measure the information from the participants against the literature that provides the theoretical setting. These chapters are centred on the issues of identity, employment and social life, the latter two being key components in our interaction with the world. Their biographies give insight into their perceptions of themselves after acquired sight impairment. The participants discuss candidly their feelings about

disruption to their sense of masculinity, about their employment prospects and changes to their social lives. Thomas (2002:2-3) illustrates the importance of employment in her referral to Britain at the time of the Industrial Revolution when

“Those who could not sell their labour-power...faced exclusion from the opportunity to independently obtain the means of subsistence – the decisive arbiter of social standing and merit in modern society (Oliver 1990; Gleeson 1999). The rest is history: workhouses, institutionalised care, enforced dependency, ‘special’ education, ‘sheltered’ workshops, community care, supported employment, and so forth.”

The third of these chapters covers the area of ‘social life’, taken in its broadest sense to encompass the various locations of social interaction. Writing from an anti-essentialist perspective, Thomas (2002:4) states that these “theoretical innovations have certainly energised our thinking about disability, and have consolidated the legitimacy of the claim that disability is a social question”. She further states that the social performance of

'disability', 'impairment' and 'being normal' has great power in the construction of self-identity.

The social model perspective of disability has relevance in this study in its application to the participants' experiences as its main themes are those of environmental and attitudinal barriers. These issues are addressed in chapters 4,5,and 6, where the biographies are examined in terms of identity, employment and social life. The findings of this study, that is, the life-histories of the participants and their relationship with previous theoretical work are then summarised in the concluding chapter.

## **Chapter 2 - The Social Model, Identity and Visually-impaired Veterans**

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This chapter is divided into sections on the medical and social theoretical models of disability, the experience of loss of sight and identity. It includes the development of the definitions of impairment and disability and makes comparisons between the medical and social model approaches to disability, thereby giving context to the material which follows in this and subsequent chapters. There are examples of the medical and social model theories on identity formation and detail on the formation of identity through socialisation and social interaction. This general information on identity is then brought into more specific relief through examination of the various routes to a 'disabled identity', particularly for people with an acquired impairment. The experience of sight loss is looked at in general terms from the charitable organisation viewpoint and then in more specific detail from biographical evidence. There is a description of the first major study into adjustment to sight loss and information from previous research conducted with war-blinded ex-service personnel especially, which has particular emphasis on their employment prospects. The chapter then concludes with various theories on identity formation in relation to the particular problems experienced by service personnel on leaving the forces.

## Medical and Social Models of Disability in Relation to Notions of 'Self' and 'Identity'.

There has been a great deal of work over the last 30 years in attempting to define disability by the World Health Organisations (1980), the Union of the Physically Impaired Against Segregation (1975) and Disabled Peoples International (1982). The International Classification of Impairment, Disability and Handicap, published by the World Health Organisation in 1980, distinguished between impairment, disability and handicap as follows; impairment being loss or abnormality occurring in an individual; disability being the restrictions placed upon that individual because of the impairment; and handicap being seen as “a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role.” (Wood 1980:27-29). This definition stems from the medical model of disability which views impairment as a personal tragedy (Oliver 1990) in that it is the cause of the disadvantages experienced by the individual “and these disadvantages can therefore only be rectified by treatment or cure” (Crow 1996).

This provides a stark contrast to the social model which “shifts the focus from impairment onto disability, using this term to refer to disabling social, environmental and attitudinal barriers rather than lack of ability” (Crow

(1996). It is, therefore, social change that is required to end the oppressive practices that disadvantage and disable people through discrimination and it is the aim of this study to identify whether or not the experiences of the participants can be understood from a social model perspective. Has there been any change within society that has affected the environmental and attitudinal barriers previously mentioned by Crow? For any change to be truly effective it must become part of the culture, a natural element of society.

The emergence of the social model of disability meant that

“disability now resided in a nexus of social relationships connecting those socially identified as impaired and those deemed non-impaired or ‘normal’, relationships that worked to exclude and disadvantage the former while promoting the relative inclusion and privileging of the latter”

(Thomas 2002:1).

Bury (1997:123) describes the three predicaments that face individuals with a ‘chronic illness and disability’ as “the *biographical disruption*” which is the initial stage of uncertainty, the “*impact of treatment*” on everyday life and, thirdly, the “long-term *adaptation and management of illness and disability*”

as people strive to “reconstruct normal life”. Bury continues with a theory on how individuals with acquired impairment attempt to allay the effects of biographical disruption either by developing a “narrative reconstruction” or by “accord[ing] the condition some ‘legitimacy’, in the sense that the chronic illness is acknowledged as a part of the individuals’ changed life style.”

Shakespeare (1996:95) describes two main approaches to identifying disabled people as a group “one based in a physical or medical understanding, the other based in a socio-cultural understanding”. The former sees disability in terms of the medical model, that is, resulting from impairment. “Disabled people are defined as that group of people whose bodies do not work; or look or act differently; or who cannot do productive work”. This definition sets a standard by which disabled people are judged in how they perform and conform, “both raise the question of normality”. The second definition sites disability as “an outcome of social processes or as a constructed or created category”. According to Shakespeare (1996:99) “Medical approaches consider negative self-identity to be an outcome of physical impairment, and focus on the need for adjustment, mourning, and coming to terms with loss”. This conflicts with the social model approach which views “negative self-identity as a result of the experience of oppressive social relations, and focuses attention on the

possibilities for changing society, empowering disabled people, and promoting a different self-understanding". Shakespeare (1996:99) quotes Giddens' approach to self-identity:

"Self-identity is not a distinctive trait, or even a collection of traits, possessed by the individual. It is the self as reflexively understood by the person in terms of her or his biography".

Oliver and Barnes (1998:66) describe the experience of having an impairment in Western society as being seen to be "abnormal", "something to be avoided at all costs". Part of this view comes from the way in which impairment is perceived to be linked directly with "poverty, social isolation and stigmatisation or second-class citizenship" (Oliver & Barnes 1998:66). If the impairment is congenital then this identity is "assigned from the moment of discovery and diagnosis". We learn our social identity through the process of socialisation – through interaction throughout childhood and on into adulthood. This continuous interaction forms our self-perception and also how we believe we are perceived by others.

Oliver and Barnes (1998:67) illustrate this point with Goffman's (1968) analysis of the "acquisition of the devalued identity" which results from a process of first understanding the value-system of society and how this

system views perceived 'abnormality' and secondly the growing comprehension of the implications of being viewed in this way.

Goffman indicates that there are several routes to a 'disabled identity', one of which is peculiar to people with an acquired impairment. This route will require an individual to reconsider and re-evaluate themselves in society's context of 'abnormality' especially as the reality of exclusion from areas within society becomes apparent. An ironic twist on this situation is discussed by Oliver and Barnes (1998:69) in that for an individual who has little economic or social status may actually take on a 'disabled identity' with some alacrity when they discover that it allows them access to "interact successfully with professionals and offers the 'benefits of sympathy and concern' from others".

This section has considered varied approaches to the creation of identity with particular reference to the medical and social models of disability. The main source of conflict between these two theories is the distinction that is drawn between disability resulting from an individual's impairment or from wider cultural/societal barriers. The following section continues this examination but from the specific position of blindness.

## The Experience of Loss of Sight

The Royal National Institute for the Blind (1997) describes sight loss as “an extremely distressing experience”. Their booklet “Seeing a future” discusses the emotional impact that people “whether... young or old, male or female, single or in a relationship, confident or shy” can expect to sustain. The biographies in the booklet illustrate the changes that have occurred in people’s lives with the overall message being one of optimism that a ‘normal’ life can be achieved after sight loss. Although there is no mention of the disabling nature of society rather than impairment, there is a nod in the direction of the social model – “Sadly, society’s attitudes towards people with disabilities can be very negative and difficult to cope with”. However, the advice given places the onus directly upon the individual to adjust and adapt to their new situation and does not offer any suggestions on how the environment can be changed e.g. approaching local Access Officers for improvements to road crossings, tactile surfaces etc.

Edwina Franchild (in Morris 1991:89) describes her experiences as a child with a visual impairment and the failure of those around her to accept or recognise her impairment.

“Blind’ meant helplessness, irrationality, hopelessness, darkness, even an association with death itself. ‘Sighted’ meant hope, rationality, capability, life. Given these choices, the adults around me tried to force me into the sighted mold.”

The experiences of servicemen who were blinded during war-time were described by Lt. Colonel Sir Ian Fraser. Fraser took on the leadership of St Dunstan’s after Sir Arthur Pearson. In his book “Learning To Be Blind”, Fraser portrays the biographies of war-blinded servicemen and their subsequent training, rehabilitation and return to work. Although the tone is optimistic for these men returning to a ‘normal’ productive life, Fraser describes them as men who “have entered the world of the blind for the rest of their lives” (1943:5). This gives the impression that, having lost their sight, these men now inhabit a different world from that of the sighted, that their identity has changed. It will be one the aims of this research to discover if the participants in this study believe that they live in a world apart and excluded from the one they lived in before their sight loss occurred.

In the 1940’s the State Council for the Blind in Pennsylvania (USA) set up a Committee to study adjustment to blindness. It is interesting to note that

this claims to be “the first scientific writing on adjustment to blindness” (1940:1) and it can be seen that the methodology is certainly of its time in that it uses solely quantifying methods to collect data. Although some of the data was produced through interviews, the agenda was that of the interviewer who had a list of set questions (1940:135) that were generally of the closed variety including those that briefly touched upon the feelings or attitudes of the participant. The quantifying nature of this approach is useful for gathering factual data that can be measured and compared. It fails, however, to take account of life-histories in any depth. The Committee itself was made up of people who worked in services for blind people but who were all sighted. These people were viewed as the experts rather than the participants who were “studied” (1940:3) and the aim of the research was motivated by a “need for better information about what makes a man or woman successful despite blindness, a need in their work with every client on their lists and, in many cases, a need in their own lives”. The research, therefore, did not recognise blind people as oppressed by society but by their own degree of success or failure in adjusting to blindness in a society organised for sighted people. It will be a challenge for this particular research to keep the ownership in the hands of the participants. My role will be that of co-ordinator and facilitator in

providing a medium for the exploration and expression of each person's life-history. (see chapter 3)

Perhaps an indication of the forward movement of theories on disability is the contrast between the work by the Pennsylvania Committee and that by Le Gros Clark (1969) in his book "Blinded in War". Le Gros Clark uses a quote from the poet Donne in his frontispiece;

"Any man's death diminishes *me*,  
because I am involved in  
*mankind*;  
And therefore never send to  
Know for whom the *bell* tolls;  
It tolls for *thee*.

The use of this quote implies, I believe, that Le Gros Clark views impairment or disability as occurring within society rather than apart from it and therefore, the issues are collective rather than individual. In fact, Le Gros Clark's insights bear a clear resemblance to social model thinking before the 'social model' was acknowledged. In his acknowledgments (1969:viii), Le Gros Clark makes specific mention of the importance to his research of "the opportunity of holding unhurried and tape-recorded conversations with many scores of war-blinded men, usually in their own

homes". This qualitative method of data collection which originates from the interpretive paradigm is described by Burgess (1988) as being "conversation with a purpose". (see chapter 3)

Le Gros Clark quotes Father T.J. Carroll of Boston (1969:12) who describes a blinded man as "a normal man under abnormal circumstances" and identifies the most important element in this situation as being that of respect, "...to be treated with all the normal marks of social equality".

There is an interesting aspect in Le Gros Clark's chapter on Working Lives (1969:53) where he appears to suggest that people with the same impairment should be discouraged from working together in groups. He states that

"it seems preferable to have not more than two blinded workers in any factory department; when their numbers are thus small, relations with their sighted fellows continue normally at a level of mutual cordiality and respect".

This is an issue that I would like to raise during the interviews for this study. Do blind ex-servicemen feel that they are perceived differently when as part of a group rather than singularly? Le Gros Clark proposes that economics

have the greatest impact on the priority governments give to social reform. His view is that a stagnant national economy focuses governments attention on productivity “In effect, they tend to narrow down their priorities to the basic working population of young and middle-aged men and women” (1969:85). This focus on output and efficiency has the advantage that it can be quantified, “whereas *social* reforms that make for greater human well-being and contentment cannot be so precisely measured in their consequences”.

Given that democratically elected governments may, potentially, be in power for a short period of time, the pressure will be to effect quantifiable results. Reforms that cannot be so easily measured will, therefore, be given a lesser priority.

From the general perspective on adjustment to loss of sight, the following section looks at issues of identity creation with particular regard to people with visual impairment.

### Identity

Oliver and Barnes (1998:67) describe how our

“Perceptions of self are...derived through the continuous process of social interaction. We come

to know who we are and how we are perceived as individuals through our interaction with other people”.

In this manner we develop our sense of self based on how we believe we are perceived by other people, “Our sense of identity is constructed on the basis of other people’s definitions”. In her article “Wounded Soldiers” (2001:22) Anabel Unity Sale discusses the situation apparently common to many servicemen on leaving the armed forces. “For some people leaving the forces, the problems of adjusting to life back on civvy street is the result of the cocooned environment they lived in, and the type of individual attracted to that”. Sale links the personality of an individual most likely to be drawn to the forces with the problems that they face on their discharge “People join the services for all sorts of reasons and those who join the army often come from dysfunctional families. The army gives them a structure and a routine, sometimes for the first time”. Sale describes these people as “vulnerable” and who “have not yet developed their independent living skills”. The single, homeless charity Crisis, estimates that “100,000 former armed forces personnel are living in hostels, on their friends floors and on the streets”. (Sale 2001:22)

The essence of Sale's article is that the majority of people who join the armed forces do so because of the identity that it gives to them and, on leaving that environment, those people lose their sense of self. It is clear that work plays a significant role in people's lives and is a major factor in determining our identity. The study by Gillies *et al* as detailed in Chapter 5 showed that work was no less important to disabled people but that their opportunities were greatly reduced. Servicemen have chosen a very singular line of work, one that is recognised as having a tough, *macho* image. What happens to that self-identity when that employment is no longer an option? Is it possible for any other form of work to create that same sense of self? In Chapters 4, 5 and 6 the participants to this study describe their experiences of changes in self-perception, employment and social interaction both in close relationships and a wider society.

Rod Michalko (2002) concurs with Taylor (1989) that identities are ready-made for us and that we assume them as we enter into the social world. Michalko (2002:5) emphasises that these identities are *made* and are not natural "The ready-made aspect of identity results in our seeing ourselves and being seen by others as types. The types that define us can be sources of enjoyment or suffering". Society recognises people as members

of a type categorised by gender, class, economics, race, sexual orientation and impairment. The medical model viewed disability as an individual occurrence, “as an “attachment”, as something extra that, for whatever reason, happened to a person” (2002:5). Michalko evokes the social model when he states that “Disability can now be understood from the perspective of politics...more than merely a private happenstance.....it is also a public matter....Disability is not an exclusively individual issue, it is a collective one” (2002:6). Michalko writes from the perspective of a man who gradually lost his sight through retinitis pigmentosa and he offers his views on his identity as a disabled person.

His work raises questions that are relevant to this study; where do we acquire our sense of identity? For example, does the blinded ex-serviceman experience multiple oppression? Michalko criticises both the medical and social models for regarding disability as either a biological condition that must be treated or as a social construction whose biological nature is overlooked.

Richard King Huskinson (The Psychology of the Blinded Soldier) states that

“Contrary to popular belief, I have discovered that very few psychological changes take place in the blinded man owing to his blindness....So long as

the blinded man is not, as it were, thrust into a special world alone, he will always remain his normal self.” (1919:311).

However, in his introduction to “Disabled Veterans in History” (2000:2) Gerber suggests that whether the impairment is physical or mental its permanency directly affects the individuals functions and therefore their ability to earn and be economically self-sufficient. Coupled with the visible nature of many impairments caused by service, the way in which exservicemen are viewed by society is frequently negative “...disabilities, impairments and disfigurements become a particularly significant marker for an individual’s or group’s social identity and self-understanding”.

The recent conflict that this country has embarked upon has given the opportunity for the media to portray the nation’s servicemen as heroic figures. It will be an interesting facet to this research to track how those same men are portrayed if they should return with lasting impairments. Shakespeare (1996:100) describes the process of assuming the role of ‘professional cripple’, where “The experience of disability as a negative identity arises out of a process of socialisation, or in the context of social relations, in which impairment is the sole focus of analysis”. Where this

negative identity is the only socially viable option the disabled person has little option but to assume the medical model distinction of 'personal tragedy'.

Through discussions and evaluation of people's experiences of discrimination, the disabled people's movement firmly rejected the "negative implications of the individualistic medical model approach to disability" and called for "an emphasis on the exclusion and discrimination disabled people face daily" (Oliver & Barnes (1998:70). The social model is concerned with removing the responsibility from the individual for the "economic and social deprivations that they encounter daily", thereby promoting a positive self-identity. This 'positivity' grows from "the redefinition of self and a recognition that the personal is political" (Oliver and Barnes 1998:77).

This chapter set out to provide context and background information which gives meaning to the information which is presented in later chapters. The information on definitions of impairments and disabilities and the medical and social model theories give an understanding to the debates that arise on identity formation. These debates influenced the manner in which the

data for this study was collected and the following chapter covers the various aspects of research design that were taken into consideration.

## Chapter 3 – Data Collection – The Rationale

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It is necessary for any research study to be clear about its objectives and the manner in which those objectives will be met. This chapter considers the issues around the methods of data collection that ensure that the resulting information is viewed as valuable and reliable. The manner in which the research is carried out must be seen to be systematic and relevant if the resulting data is to be creditable. Within this chapter, the broad view of the methodological philosophies will be outlined and the specific methods applicable to this particular research will be identified. There is a description of how the data will be collected. This testimonial information will then be compared and contrasted in later chapters with material from other studies, some of which have been mentioned in Chapter 2. A discussion follows on the merits and demerits of the quantitative and qualitative methods of data collection and the argument for the appropriate method for this research. Context for the choice of study topic is given with information on my relationship to the research subject. The method and manner of data collection is detailed and the rationale for linking this with the interpretive paradigm. The timetable for the research is

shown and this together with the other choices made for information gathering will be evaluated in the concluding chapter.

### Paradigms

There are debates and differences between sociologists as to how knowledge of the world is obtained. Varying paradigms compete to provide “an overall framework of ‘assumptions, ideas and techniques’ for how we understand social reality.” (Barnes & Mercer, 2002/3) The central belief that forms the basis for positivists is that “sociology should be scientific – meaning that it should use, as far as possible, the procedures for considering evidence developed by the natural sciences” (Kirby et al:1997:60) This objective reality aligns with the view that social actors and their actions can be observed and measured in a quantitative method. Therefore, if various factors are introduced to a social group, their effects can be measured to test hypotheses as with the research conducted by the State Council for the Blind, Pennsylvania, USA detailed in Chapter 2. The interpretive paradigm recognises that there are basic differences between natural and social sciences. While positivists believe that the science of sociology can adapt the methodology of the natural sciences the hermeneutic/interpretive approach regards interpretation as a vital key in

understanding the social construct of knowledge. Interpretivists are united in “a belief in the social construction of social reality (in sharp contrast to the realism espoused by positivism), and a celebration of ontological relativism (i.e. there are multiple realities rather than a single, objective social reality).” (Barnes & Mercer;2002/3:7) The notion of multiple realities recognises that research is dependent upon each persons interpretation of their world and that each interpretation is based upon the context of the individuals reality. Therefore, data emerges not as phenomena but as the product of the interaction between researcher and participant. Rather than the quantifying methods of positivism, interpretive research values qualitative collection of data. However, “Critical social science embraces all those approaches in sociology which aim to be critical of society in order to facilitate social change” (Haralambros & Holborn;2000:982) Transformation of society and thereby the lifting of oppression can only be achieved by the never-ending quest for knowledge in an effort to understand the values by which society functions. Critical theory views apparent societal values and the “true values underlying them” (Haralambos & Holborn;2000:982) as quite different and it is only when the underlying values are brought to the surface that society can be changed.

Shakespeare and Watson (1997) contend that the social model cannot address the experiences of disabled people. They state that criticism has “centred on the inclusion of impairment and personal experience within the social model, and have been hotly resisted by other activists and theorists of the movement” (1997:293). They cite Finkelstein as one of the these who “has recently argued strongly and widely that the effect of considering personal experience and impairment is to dilute the effectiveness of the social model” (1997:293). My particular approach to this study has been the extended social model as advocated by Thomas in 1999 and which is discussed in more detail in Chapter 4. This theory recognises the social model definition of disability as social oppression but extends it into the psycho-emotional domain. Therefore, the individual experience of impairment and disability is a valuable contribution.

The methodology of this research project is founded on data collection of life histories through interviews thus rejecting the quantitative approach of positivism as being inappropriate for this study. The qualitative nature of this research is reflected in the production of theories from the collection of data from the participant’s own words which “relate to feelings, processes, actions and meanings” (Barnes & Mercer;2002/3:9). This process is an interaction between interviewer and interviewee. It therefore, relies heavily

upon the relationship between the two. In this area I have an advantage in that a mutually respectful and trusting relationship already exists between myself and the people I have chosen for this study. Whilst I can agree with the principles of the critical theory it would be unrealistic to hope that this study will have any great impact on the social reality experienced by the participants. In fact, the aim of this study is to try to ascertain what impact, if any, social model thinking can be used to explore the experiences of blind ex-servicemen. The methodology is necessarily rooted in the interpretive paradigm in looking at how people comprehend and explain their world.

### The Research Process

The basic aim of the research methodology is to study the material outlined in chapter 2 and contrast and compare it with the data collected from the research participants. The objective then will be to collect empirical data to either support or contradict the question of whether or not social model thinking can explain the lives of blinded servicemen. The data from the interviewees will be identified by an initial letter only, preserving confidentiality. A small biography of each person can be found in Appendix A.

My work as Welfare Officer with St Dunstan's brings me into daily contact with men and women who have lost their sight while serving in the armed forces usually in traumatic circumstances. The degree to which I am able to enable or empower these people in their lives is largely dependent upon the relationship that I am able to build with them. This necessitates a close, trusting and confidential relationship as intimate and personal details are frequently given. It is because of this relationship that I believe that the chosen participants will be able to speak freely of their experiences. It was important that the nature of this relationship did not compromise the rights of each participant to confidentiality and anonymity. I first contacted St Dunstans for their assurance that the manner of data collection for this study did not contravene the Data Protection Act. I then produced a letter for each of the interviewees which stated clearly that the information that they gave to me was strictly confidential, to be used for the purposes of this study only. They were also assured that pseudonyms would be used. This information was then reiterated at the beginning of each interview.

The Sample

The sample is purposive as I have chosen people who are relevant and significant to the study subject. Although this leaves the research open to questions about the sample reflecting judgments that I may have made in their choice, I believe that their input makes a valuable contribution. The alternative would have been to rely upon secondary information and the opportunity to generate new data would be lost.

There will be six interviews held across the country. It would have been easier to have chosen people who lived in the same area but it was not possible to select people on this basis. This was because, with changes in the nature of armed conflict since the first and second World Wars, fewer servicemen are blinded. The criteria for the choice were:-

1. The sight loss should have occurred during service. This means that those St Dunstaners who lost their sight through other means after they had left the forces could not be included. It may have been beneficial for this study to have had a greater number of interviews but, realistically, the time available was not sufficient and I felt it more important to have fewer in-depth interviews than more interviews held on a superficial basis. It is important that the participants have enough

time to be able to explore their own story rather than be held rigidly to a script because of time restrictions.

2. The participants were chosen from a variety of conflicts over a period of years thus allowing comparisons to be made in their respective experiences. Again, however, the small sample means that the information gained from the interviews will be specific to the individual. Although this does not invalidate the data given, it does mean that there will be a lack of corroboration from other servicemen from the same period and this could be seen to affect the reliability of the data.
3. The people chosen for the sample are from varied backgrounds and held different ranks and positions within all branches of the forces. Although this may diminish the strength of the sample still further it should mean that their experiences are based on their sight loss and not on any external factors such as the efficacy of the discharge board of any particular service or on the level of assistance given to officers or non-commissioned personnel. However, any information related to differing experiences due to rank or service type is of relevance and would be included in the findings.

Table of Interviewees (*pseudonyms have been used*)

<u>Name</u>	<u>Rank</u>	<u>Age</u>	<u>Date of Sight Loss</u>	<u>Discharge Date</u>	<u>Marital Status</u>	<u>Employment</u>
John	Corporal	33	1997	1997	Yes	No
Mark	Corporal	45	1987	1988	Yes (second)	Self
Roy	Corporal	58	1973	1973	Yes (second)	No
Carl	Guardisman	29	2000	2002	Yes	No
Dave	Petty Officer	52	1995	1981	No	No
Tom	Chief Petty Officer	59	1982	1982	Yes (second)	Yes

### Interviews

The interviews took place in the interviewee's own homes where they are relaxed and able to contribute freely. There was no specific time limit as this could have created tension and the participant may have been unable to give as much information as they would like. However, the interviews were semi-structured as opposed to structured or unstructured so that there was a broad frame of relevance. It would have been possible to follow the positivist route and use a quantifying method through a postal questionnaire. This would have saved time in travelling and would have enabled me to access a greater sample to be accessed. It would also have meant that the data produced from this method could have been more

easily compared with existing data. However, this does not accord with the interpretive paradigm, which, as has already been suggested earlier in this chapter, is one of the driving forces of this study. The information sought was that of a qualitative nature with its essence being held in the biographies and experiences of servicemen. It would have been impossible to achieve the necessary detail and breadth from a questionnaire. According to May (2001:98) the disadvantages of postal questionnaires are,

“the need to keep questions relatively simple...as the researcher has no control over how people are interpreting the question...the possibility of probing beyond the answer is absent...there is no control over who answers the questionnaire...”

There is also the question of whether a postal questionnaire is an appropriate medium to be sent to a sight-impaired person.

So, the interviews had a framework of questions designed to gather information about the interviewee's experiences. The questions focused on their lives before the incident which caused their sight loss. In particular, explored areas of employment, relationships with family and friends, citizenship and the degree of support available from statutory and voluntary

agencies including that of the relevant section of the armed forces. As the purpose of this research is to study a number of issues it was not possible to hold totally unstructured interviews. Many ex-service personnel are more than willing to talk at length about their experiences and the time restrictions meant that the interviews had to have structure so that useable data was achieved. Referring back to Chapter 2 and the description of the various 'types' that create our socially constructed identities, the participants share many of the categories – they are all men, all from the same ethnic background and are all within a 20 to 30 year age grouping and, of course, they have the same if not similar, impairment. The questions throughout the course of the interviews tried to establish what gave each man his sense of identity. If those factors included class and position in society prior to enlistment, were they exaggerated or diminished in service? On their subsequent medical discharge did their notion of identity change and, if so, how? Does each man view himself as an exserviceman, a blind man, a disabled man? And what were the contributing factors that created the new identity?

The interviews were recorded and then transcribed in full. The written accounts were then studied and analysed for data that is appropriate to this

study. That material was then catalogued and used to compare with the existing information.

### Timetable

The timetable for this work was as follows:-

- April – telephone the participants to ‘set the scene’. The participants have already approached but this is the formal aspect.
- April – produce a letter/or tape regarding confidentiality and mail to the participants.
- April/May – conduct the interviews
- June – transcribe and evaluate the data
- July – encompass the data within the study

### Discussion

Duckett and Pratt (2001:815) state that “Disability research has been criticised for not contributing directly enough in the emancipation of disabled people from oppressive social practices” and suggest that this has prompted discussion on the relevant importance “for research to be grounded more in the political concerns of the field than the academic concerns of researchers”, thus “Epistemological issues remain important,

but these are now more explicitly joined by the morals and values that provide a driving force behind disability research” (2001:816). Duckett and Pratt have found that in disability research generally, there is evidence of the growing use of empowering and emancipatory research design which “contrasts quite starkly” with “examples of research informed by an empowering and emancipatory paradigm involving visually impaired people”. I am very much aware that this particular study could be criticised for failing to be emancipatory in the fashion of that carried out by Duckett and Pratt. Their participants were invited to choose which areas they themselves wished to be the focus of research and were then involved in the research design. The participants in this study will have had the research topic chosen for them but its saving grace could be seen to be the empowering nature of the interviews using the approach suggested by Duckett and Pratt based on “non-judgmental acceptance of each participant’s experiences....participants become the experts and the researcher the novice.... Viewing the participants as collaborators rather than subjects and....avoiding acts of deception and freely eliciting our own feelings and experiences”.

## Conclusion

This chapter has examined the process of research design for this study. It has looked at the issues of paradigms, data collection and the research process in general and has then considered them in specific detail, relevant to this work. The information contained here provides the framework for the study as a whole and also explains the philosophies and theories which are appropriate. The following three chapters examine the theoretical formation of identity in relation to specific areas of life; identity itself, career and employment and social interaction. The theory is juxtaposed with the biographical detail supplied by the participants to this study.

## Chapter 4 – A New Identity?

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Having set the scene for the methodology of this study in the last chapter, chapter 4 looks specifically at identity formation as introduced in chapter 2. Moving from general aspects of identity to the particular issues for disabled people, this chapter takes account of specific questions for people with acquired impairments. Theories are included on the experience of stigma and the mechanisms which may be employed as coping strategies as people struggle to be perceived as 'normal'. The debate concerned with the validity of biographical histories is discussed as it has particular relevance. This chapter also contains theoretical discussions regarding the experience of change of identity and how people cope with that through denial, 'passing' or other means. These theories are examined in relation to data collected from the participants.

### Social Construction of Identity

Goffman (1963:12) explains how society bestows a 'social identity' upon people based on first appearances categorised by their attributes which are personal as in character traits or structural as in occupation. "We lean on these anticipations that we have, transforming them into normative

expectations, into righteously presented demands.” There is a distinction to be made between this “virtual social identity” that is created for an individual and their “actual social identity”. Goffman describes the discrepancy between the two identities as “stigma” where the difference is “incongruous with our stereotype of what a given type of individual should be” (1963:13).

Dave’s testimony shows an insight into his view of the virtual social identity that he believes belongs to a person with visual impairment and the actual social identity that he sees as his own,

“I’ve never been what I call a Butlin’s person...I prefer being by myself, I’m not typical of the blind population”

It can be seen here that Dave sees blind people as a group identifiable by an identity bestowed by society but views himself as individual and separate. This links with the quote from Barnes and Oliver at the beginning of the next section regarding Disabled Identity.

Goffman continues his theory by discussing how society exercises discrimination in a variety of areas based upon the assumption that a person with a stigma is “not quite human”. “We construct a stigma theory, an ideology to explain his inferiority and account for the danger he

represents, sometimes rationalizing an animosity based on other differences, such as those of social class” (1963:15). The phenomenon may occur where a range of ‘imperfections’ may be conferred based on evidence of the original or ‘supernatural’ attributes may be imputed. How many times have people been heard to remark on the amazing powers of the remaining senses of people with a visual impairment as though the diminishment of one sense automatically grants an individual super-human powers.

### A ‘Disabled’ Identity

Oliver and Barnes (1998:66) describe the link between an impairment and identity as

“To become ‘disabled’ is to be assigned a new identity indicating membership of a separate tribe or species. To be born with an impairment is to have this identity assigned from the moment of discovery and diagnosis. Both involve a social learning process in which the nuances and meanings of this identity have to be assimilated or addressed”.

This point was addressed by Roy who lost his sight instantly as a result of being blown up by a bomb in Northern Ireland,

“When this happened to me in 1973 my whole life changed then. At the very beginning I was very bitter about what happened to me because I lost my independence. Missing things you used to do...most of your independence goes but you can get some of it back...walking from A to B with a cane or a dog”

Roy then described the other ways in which the incident affected him,

“I can talk now about what happened but years ago I couldn't. It used to distress me, especially because of the lads who were killed with me. I kept blaming myself...I lost my sight but they lost their lives”

Anyone who has an impairment may find themselves in the position of having to accept assistance from other people to accomplish, sometimes, quite intimate tasks.

“This may lead to a reconceptualisation of the individual's identity and self-image to incorporate

loss of physical sensation, dependence on others, and exclusion from valued social activities” (Barnes & Mercer 2003:9).

This reconceptualisation can take time to develop. Initially, the experience of Ray was that of shock and disbelief,

“I had three operations to try and recover some sight. I remained there until about October (*from July*) during which time I was told that I would never see again, but as it takes a while for your optic nerves to die you still cling to the very faint hope that a mistake has been made and that it’s only a matter of time before all will be well again”.

Therefore, “Attention turns to the reconstitution of the individual self, and the negotiation and renegotiation of identity through talk” (Charmaz in Barnes & Mercer 2003:9). That is, the manner in which people use various methods to achieve ‘normality’ thereby projecting an image of themselves that highlights the “‘capable self’ rather than the ‘disabled self’” (Corbin and Strauss in Barnes & Mercer 2003:9). There is some evidence from the testimony of John to suggest that the discipline and culture of life in the

armed forces has an effect on the way in which ex-service personnel adjust to acquired impairment;

“Being in the forces develops a positive mental attitude, that’s why so many ex-forces cope better than civilians with disabilities. They’re trained to look for solutions. You’ve got to be confident, that’s what the forces taught us.”

Perhaps that accounts for Tom’s apparent phlegmatism when it was confirmed that he would be totally blind as the result of aircraft fire during the Falklands War,

“Bit of a shock obviously, to lose the last shreds of hope but it was better really...I knew the bottom line”

This information and the supporting testimonies of the other interviewees appears to contradict the article by Sale (2001) as discussed in Chapter 2. Where Sale views ex-servicemen as vulnerable on discharge owing to their reliance upon the regulated life within the forces, each participant in this study, after initial anxiety,

“I didn’t know what I wanted to do...my mind was blank, had been for several months, I just had no idea what I was going to do” (Dave)

and Tom,

“I didn’t know quite what I planned to do”

has forged a new life and new identity in seeking out alternative employment. This information can be found in Chapter 5 which focuses on employment.

As discussed later in this chapter, there is debate over the validity of individual experience of impairment. However, as reflected by the biographies of disabled women, as in Jenny Morris (1991), it is possible for oppression to exist within the many layers of society, disabled or otherwise and therefore credence has to be given to personal accounts of impairment and disability. The necessary caveat should then be that personal biography is valuable as specific detail which informs the consensus of experience as a whole. The danger being that to focus solely on the personal experience of impairment and disability can reinforce internalised oppression with all of its negative implications regarding identity.

Shakespeare defines the methods whereby an individual may actively deny their disability, attempting to reduce the stature of their impairment by

camouflage. One form of denial may be religious in its form “a resignation to fate or the will of God” (1996:100), a theory echoed by Tom who reported,

“I wonder if it’s all mapped out beforehand, whether it’s fate”.

And also by Mark at the point of diagnosis with Retinitis Pigmentosa,

“I accepted it because there was not a lot I could do about it anyway, because the colonel said there was no cure and they couldn’t improve it so it was just a case of get on with it.”

This fatalistic attitude was echoed by Roy,

“I think if I hadn’t lost my sight I wouldn’t be the person I am today, I think it’s bettered me. As a soldier I was a fiery bugger but being in the blind world has really changed me.”

An alternative strategy more common amongst disabled men “involves a refusal to submit to reality, and an attempt to regain a normal identity through superhuman activity and endurance, for example in the case of many sporting activities”. It is argued by Shakespeare that none of these acts of denial

“are psychologically or socially healthy or progressive. They involve an element of denial or failure to come to terms: they all involve a significant element of external definition, of accepting external disempowering agendas. A temporary or compromise identity may be developed, but it is frail, and ultimately has costs for personal psychological happiness and security.”

There is a marked difference between the way in which Carl and Tom have accepted and/or adjusted to their experiences. Carl had his eyes gouged out by a fellow soldier,

“I don’t bear any grudges towards him...Although I was forced to fight for my life and left in a coma for eight days, I did not and still don’t blame or hate him for what he’s done. I think maybe I’m a better person now than I would have been”

and Tom was the only sailor to be blinded during the Falklands War,

“The actual inner man...I had 24 years in the Navy and I loved it. It was the last bastion of male chauvinism...I’d do it again knowing the outcome. I

do wonder why did it happen to me? Why was I the only one? Why was it just the eyes, not the ears? Going into social work was to try to make something positive”

It is most likely that a number of factors produce such varying responses to what is, in effect, the same outcome. Those factors will include personal character, the nature of the sight loss and also the time elapsed between the incident and the point of discussion. Tom describes his feelings on the person he sees himself as today,

“The inner man is not really all that stressed. In the early days I wanted to change the world but I’ve mellowed. In my thirties I was in a leather jacket and sports car...and then this. Suddenly, you realise how vulnerable you are. I try and live for the present.”

Reeve (2002:13) describes the various circumstances where a person with an impairment may view themselves as disabled or not, “People may identify as disabled in one setting but not in others”. She illustrates this point with the experiences of one of the participants of her study who “described how she identifies as a ‘disabled person’ at work, but elsewhere

in her family and social life, her identity is that of mother and woman – her impairment and disability are not part of her identity in these other settings”. The interview with Roy revealed his love of amateur radio where

“They’re like you, they can’t see you. I can’t see them so we’re all the same.”

In that context Roy is liberated from his ‘disabled identity’; his identity is created by his ‘handle’ or radio name. Therefore, the issue of identity is not a fixed site but rather a moving point on a complex continuum. John puts this succinctly;

“I can’t deny that some people think of me as a disabled man, I don’t see myself that way. We’re all individual. There’s disabled people around the world and we are all different.”

Despite this statement and the fact that Roy perceives himself to be an individual he actively seeks out people who conform to the same image,

“I’m a bit of a loner, I don’t go to societies. I only go down to St Dunstons for the comradeship...you’re all in the same boat”.

More recent discussions about the social construction of 'disabled identity' have suggested that recognition of difference can have the power to be a positive rather than negative experience. However,

“This...postmodernist preoccupation with difference has shifted attention from a comparison of disabled and non-disabled people to studies of divisions within the disabled population. It is equally necessary from a post-structuralist perspective to 'deconstruct' these new identities as much as the traditional ones” (Barnes & Mercer 2003:12).

This is an area that has been raised in the interviews for this study. That is, the fundamental question of whether the participants believe that they have had an identity imposed upon them by society. For example, that of 'professional cripple' as described by Shakespeare in Chapter 2. And, if so, what are the components of that identity; impairment, sex and gender, race, ethnicity, social class, economic status? The imposition of a rigidly constructed identity is oppressive and restrictive and requires an individual to conform to the expectations of that identity. The interview with John highlighted this conflict between his self-identity and that being created for him by other members of society;

“People try to be too helpful, too kind. They always want to do things for you. You get the feeling you’d like to shout at them, ‘stop it!’, be rude, you don’t want to be nannied. I’m still a human man, I feel the same as any human male. I don’t want to be mollycoddled and nannied so much.”

John finds himself being forced into the persona of a vulnerable, incapable and dependent man whereas, it is quite clear, his self-perception is that of a much different person.

Somers suggests an alternative approach that circumvents the creation of a rigid identity from one defining factor. Using the “categorically destabilising dimensions of time, space and relationality” identity becomes a more fluid entity created from experience, observed behaviour and emotions. Identity is therefore, constructed socially and shared collectively but is also relevant to individuality.

### The Social Model in Relation to Identity

In Reeve’s paper on psycho-emotional dimensions of disability and the social model (2002:1) she discusses the advantages of embracing the social relational model of disability that was proposed by Thomas in 1999.

This theory accepts the definition of disability as social oppression and exclusion but extends into the structural and psycho-emotional fields. “In this model, disability is seen as a form of social oppression which operates at both the public and personal levels, affecting what people can *do* as well as who they can *be*” (Reeve 2002:1). Reeve’s evidence of psycho-emotional disablism is explored further in this chapter as being relevant to the debate on disability and identity.

The article by Barnes and Mercer (2003:1) describes the “Polarisation of impairment and disability” and suggests that a “focus on impairment and associated experiences risks undermining the social model’s political project” (Oliver 1990,1996c). However, the more recent debates over the reintroduction of impairment and its “reformulation” (Barnes & Mercer 2003:1) have highlighted the “diverse theoretical and political standpoints”. The debates regarding experience encroach on the areas relating to the medical model view of disability as individual and treatable as opposed to the social theory’s “interest in difference and the development of multiple identities” (Barnes & Mercer 2003:1) which gives greater weight and relevance to experiences, perceptions and feelings than socially constructed identities.

Foucault refers to a process called 'normalisation' to describe the way in which "the developments of modern medicine" allowed the growth of "a new form of disciplinary power concerned with control of human bodies" (Kirby 1997:362). This desire to control and amend deviation from the norm firmly echoes the medical model of disability.

Foucault is clearly on the same wavelength as post-modernists in his rejection of the notion that it is possible "to use sociological concepts to analyse the structure of society as a separate identity" (Kirby 1997:383). He also rejects the idea of a "structural reality below the surface of social life which directs human behaviour but of which we are not always aware". Instead, Foucault addresses the impact of "knowledge, language and culture" in society. This indicates an affiliation with an interpretive rather than positivist paradigm. (Kirby 1997:383)

For Foucault, "power exists within culture but in terms of a huge variety of different 'power-knowledge' relations" (Kirby 1997:383). These power-knowledge relations shape culture at the micro level creating a complex web of "discourses, each offering particular ways of understanding aspects of our behaviour" (Kirby 1997:384). Thus we have discourses on sexuality, employment, ethnicity, gender, relationships and disability. Foucault argues that "our sense of self-identity actually comes from the way in which

we are positioned in relation to particular forms of knowledge or discourses” (Kirby 1997:384). In relation to this particular research Foucaults theories raise questions about who holds the position of power in the relationship of the blinded ex-serviceman to his medical and social environment. If he rejects and resists his ‘disabled identity’ the fight for power “is then about the discipline and control of the body” (Kirby 1997:718).

Barnes and Mercer (2003:2) state that “the presence of an impairment does not mean automatic transfer to the status of a disabled person” rather, “it becomes an issue at the point where social barriers exclude that individual from participation in everyday life activities”. According to Shakespeare (in Barnes & Mercer 2003:4) the disability movement has changed the focus from “the link between our bodies and our social situation” to “the real cause of disability, i.e. discrimination and prejudice”. Following this hypothesis, Finkelstein (in Barnes & Mercer 2003:5) describes the division “between those who concentrate on challenging disabling social barriers and those who want to explore the attitudes and emotions associated with the personal experience of impairment and disability”.

Critics of the early social model approach which based the root cause of disability as being solely structural, propound that the experience of disability and impairment is “holistic” (Thomas 1999:43) as substantiated by Jenny Morris (1991:10)

“There is a tendency within the social model of disability to deny the experience of our bodies, insisting that our physical differences and restrictions are *entirely* socially created. While environmental barriers and social attitudes are a crucial part of our experience of disability – and do indeed disable us - to suggest that this is all there is to it is to deny the personal experience..”

The basis of this research study is the acknowledgment of the socially constructed aspects of disability and also the belief in the relevance and value of individual experience of impairment. If the value of personal experience is not recognised then there can be no appreciation of “the potential for considerable variation in the experience of both impairment and disability across the disabled population (Barnes & Mercer 2003:5). It can be seen then that there is a plausible case to be made for the social theory of “‘flexible’, ‘multiple’ and ‘contested’ identities”. For the

participants in this study, the notion of identity could be fed by a variety of factors other than their impairment and sex; sexuality, social class, ethnicity, economic status.

Thomas (1999:60) puts forward a definition of disability, an extended social model, that addresses the divide between the emphasis on socio-structural barriers and the emphasis on cultural and experiential factors, “Disability is a form of social oppression involving the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their psycho-emotional well-being”.

This definition is taken by Reeve (2002:2) to express the comprehensive manner in limitations are placed “on what disabled people can both *do* and *be*”. Reeve suggests that this form of disabilism is “the most restricting” and that the “agents” can be people with whom the disabled person has a close or direct contact such as family members or ‘professionals’ besides society in general.

Morris (1991:25) uses testimonies from disabled people to illustrate “the sense of unease each time we interact with the non-disabled world, particularly in a public situation where we are dealing with strangers’ reactions”. This is described by Reeve (2002:3) as “the effects of psycho-emotional oppression...sustained through imagery, cultural representations

and interactions with others”. Morris (1991:30) describes her own experiences with incidental contact with other disabled people. Encounters have the tendency to fall into one of two categories; either “we can smile at each other, exchange a few words and feel good about our feeling of identifying with each other” or, “other disabled people avoid catching my eye because of the negative way that we are made to feel about ourselves...” This latter category is illustrated by Dave who reported

“I prefer being by myself, I’m not typical of the blind population, that’s why I don’t go to St Dunstons anymore”.

This chapter has drawn on the theories of identity formation and extended them to look at the ways in which people cope with a change of identity imposed through acquired impairment. Testimonies from the study participants has illustrated notions of identity in relation to the social and medical models of disability and through to the extended social model to include the experience of psycho-emotional oppression. The following chapter takes these ideas and views into the areas of rehabilitation and employment.

## Chapter 5 – A New Career?

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The preceding chapters have given, in detail, the various theories on identity formation in general and with regard to impairment in particular. This chapter deals with identity in employment, a considerable factor in how we view ourselves within society and how we are assessed. It will be argued that the role of charities in providing rehabilitation and training and the manner in which they raise funds for those purposes could be viewed as perpetuating the medical model of disability. There is also examination of the view that employment is yet another means of segregation. As discussed in Chapter 2, the social model of disability identifies disability as socially constructed. Employment is then, an arena for the fight for inclusion.

### Disabled People and Employment

The experience of unemployment or underemployment has been a commonplace occurrence for disabled people. Chapter 4 detailed the theories of Goffman who linked impairment with stigma. A form of stigmatisation is visited upon people who are economically reliant upon

state benefits. This represents a double stigma for disabled people who are unable to work thus reinforcing a negative self-image.

Castleton (1990:14) documents the experience of Tommy Rogers, an early St Dunstaner who was taught to touch-type,

“Still my life was one of frustration. However, I had helped some of the fresh trainees to type their own letters with the result that when a new typing teacher was required, the post was offered to me. I accepted and with that acceptance the light began to disperse the mist of frustration. Once again I was a useful member of society.”

According to Barton and Oliver (1997:121) “Work not only has financial repercussions; there are also spinoffs for social and political status”. A common question from each of the six participants in this study was what would they do now that they had lost their sight and their employment?

“I didn’t quite know what I was going to do now”

(Tom)

“What do I do now?” (Roy)

For each of the six it was not just a question of losing employment; their anxiety was based on their loss of self-identity. Their jobs had made them who they were and that had been lost to them.

The study by Gillies, Knight and Baglioni in 1998 measured the perceptions of employment of non-disabled people and people with a visual impairment. The results showed quite clearly that both groups of participants view a working life as equally important. However, the group of people with a visual impairment were considerably less satisfied with their career in terms of development, service and training. “Despite numerous... initiatives, disability groups experience a significantly higher rate of unemployment than the general population” (Gillies, Knight & Baglioni 1998:6). A major factor in the way that disabled people experience discrimination within the workplace is the attitude held by society towards people with impairments having careers. This pervasive approach results in greater difficulties in accessing information about careers and the labour market itself. The policy statement of the Union of The Physically Impaired Against Segregation (1976) has this to say about employment;

“When we do succeed in getting employment, our comparatively low productivity means that we have low bargaining power when it comes to negotiating

decent treatment and facilities...We are usually among the first to lose our jobs and be cast on the scrap-heap when it suits the 'needs' of the economy.”

The ingrained attitudinal oppression within the workplace can make employment, once achieved, a negative experience as non-disabled people display their perceptions of what they believe disability to be. Conley (in Gillies et al 1998:398) Refers to the “wall of prejudice” that disabled people frequently meet in the workplace, being considered different and inferior. Statistical evidence from studies by Wolffe, Roessler and Schreiner in 1992, Thurman in 1983 and Jagger, Neukrug and McCauliffe show that visually impaired people are vastly under-represented in employment figures. A study by Clayton in 1983 (Gillies et al 1998:399) argued that the attitude of possible employers is a major barrier. This attitude comprises fear and ignorance and is illustrated by employers' concerns that the employee is likely to be faced with increased vulnerability. Employers are also likely to be overly concerned with safety issues and the possibility of huge claims for compensation. These barriers compound the difficulties faced by people with a visual impairment who may have already experienced discrimination by resettlement officers who may have very

stilted ideas on what constitutes appropriate employment. The third barrier is that of technology which advances more quickly in the workplace than it does in the field of aids and adaptations leaving the visually impaired person to compete on an unequal basis. Legislation requires employers to make working environments suitable for the needs of disabled people but many are reluctant to invest in the necessary equipment which is often expensive. Even where visually impaired employees have gained employment the opportunities to advance within a career structure may well be problematical through attitudinal discrimination. The Clayton study (1983) results showed clearly that access to employment and training for employment was equally important to people with a visual impairment and non-disabled people alike but that the former group were much less satisfied with their training opportunities and their career development options leaving a distinct perception of themselves as disadvantaged in their access to employment.

Tom, the only interviewee to retain employment in the Navy, albeit in a very different role, described his new job as “a sympathy job” and describes his decision to leave;

“I got involved with a local visually impaired group  
and I thought ‘these people aren’t getting a service

at all'. I thought 'I've had a luxury service (St Dunstons) and maybe I should be doing something about this because the Navy was a soft option. I thought 'I've got to make a break some time and so I came out at 39 ½ and trained as a technical officer and then did the social workers course."

Following several years as a social worker for people with a visual impairment in Aberdeen, Tom then moved to Birmingham to a post as lecturer with the National Mobility Centre. Then, as he puts it

"the nice job disappeared...I had a mortgage, jobs gone"

when the offices were relocated to a part of Birmingham that was inaccessible for Tom by public transport. Thus, despite being capable and qualified to do his job, Tom was prevented from continuing with his employment because of the environmental barriers and also the attitudinal barriers which failed to consider his particular needs.

These barriers were also experienced by Mark in a somewhat bizarre fashion. After the diagnosis of Retinitis Pigmentosa, Mark was retained in the Army and given responsible work while at the same time was constantly downgraded medically and passed over for promotion. Mark

was required to continue going out on 'exercises' and 'manoeuvres' which caused him little difficulty during the day but which became an impossibility at night when his vision was most severely affected.

“At night, that’s when the problems started for me, walking into trees, falling into holes. That’s when they stopped me going out on exercises. The ironic thing was they still had me doing guard duty at night.”

Morris (1991:118) writes of the segregation that disabled people experience through being separated from mainstream society. This occurs in education and leisure and also in the employment marketplace where employers are disinclined to engage staff who may have needs that require fulfilling with regard to access or equipment. These needs coupled with negativity generated by disablism make disabled people virtually unemployable for many employers.

In the case of Dave, who was working for Saudi Airlines at the point at which he became sight impaired, the initial reaction of his employers was to send him for medical examinations and then treatment. Dave reports

“I was still going into work but I knew it wasn’t going to work...I had to sit in front of a medical committee...it was dragging on and on.”

The only option considered by the employer was medical intervention and, when this failed to restore any useful vision for Dave he found himself in an unenviable position

“I got word a few weeks later...’This employee is incapable of working in any capacity for Saudi Airline.’ The manager said...sorry, you can’t work for us anymore. Anyway, it was the medical people that got rid of me”.

This statement indicates the dominance of the medical model of disability operating in this workplace. Dave’s visual impairment was perceived as his individual problem and one that made him unemployable.

Dave acknowledges the cultural differences between Western and Eastern employment practice

“It’s a totally different situation to this country, the Saudis are renting people and you don’t go out and rent a defective car. If the car breaks down, you get rid of it and get another one”.

British legislation regarding employment and disability is supposed to ensure that any employee who acquires an impairment whilst employed is given every possible assistance by their employer to find an alternative position. And yet, only one of the six men interviewed was supported or encouraged to continue their employment with the armed forces. Instead, the majority were 'resettled' into civilian life.

French (1993:75) describes the decision facing disabled people when seeking employment – “whether or not to deny disability”. This decision is made in the face of attitudes which are inflexible and which require jobs to be done in a specific way which fails to recognise differing needs of people. French states that this is almost preferable to deal with than

“the situation now, where ‘equal opportunity’ policies have simultaneously raised expectations and pushed negative attitudes underground, and where, in reality, little has changed”.

Mark's experiences in the Army show that this situation is still in evidence. Whilst his employers followed the letter of the law in finding him alternative employment, they failed to follow the intent by providing him with an unrewarding and unsatisfying job that failed to utilise his skills and attributes.

“Eventually they took me away from my duties and put me in the unit shop. I thought it was a bit of an insult, I did feel I could have kept doing my trade in the warehouse or the office but they never gave me that option. They basically took me out of my job and stuck me in the shop and that was it.”

Reeve (2002:9) describes how the two dimensions of disability, structural disablism and psycho-emotional disablism can “interact to affect the economic disadvantage faced by disabled people”. Despite legislation that was intended to provide disabled people with the legal right to compete in the labour market, (the Disabled Persons Employment Act, the Disability Discrimination Act and the more recent Human Rights Act) “there is substantial evidence of the level of disadvantage disabled people encounter in the modern labour market” (Oliver & Barnes 1998:43). Discrimination is a major factor in the lack of employment of disabled people, however, it should also be remembered that “there will also be some disabled people who do not feel confident enough to apply for jobs for which they are eminently capable because they have internalised the negative value afforded disabled people in society” (Reeve 2002:9). The

end result may well be a downward spiral where “the psycho-emotional dimensions of disability can operate in conjunction with the experience of structural disability, further increasing the level of exclusion and material disadvantage experienced by people with impairments” (Reeve 2002:9).

Dave echoes this point when he reports

“I didn’t know what I wanted to do, my mind was a blank, had been for several months. I just had no idea what I was going to do. I totally missed the engineering, I especially missed the amount of power I had on the airport”.

For Dave the loss of his job meant the loss of his perception of himself, his self-identity as a productive, economically self-sufficient person.

Tom was the only one of the six interviewees who retained employment within the forces.

“I went back to the air station and got a job in the museum as information officer, doing presentations. I’d learned the aircraft by heart and I was doing presentations to the public and local groups.”

Tom attributes the apparently welcoming attitude by the Navy as being attributable to the fact that he was the only serviceman to be blinded in

their first real conflict for several years. It's interesting to note that a different kind of prejudice caused Tom to give up this employment.

“I remember giving the presentation to this young Wren, only about 19, and I was 38 and I remember thinking ‘I bet you think I’m an old fart!’ and I thought I’ve got to get out of this.”

### Identity and Employment

To be employable, to be in employment is a marker in society, a kind of ‘coming of age’ as it were that is proof of adulthood and allows a measure of self-esteem.

During his interview Tom illustrates this point

“I joined the navy for a five year apprenticeship, you were considered a tradesman, a kind of elite.”

Tom then describes his thoughts following his sight impairment,

“I didn’t know quite what I planned to do, I brainstormed and looked at other role models from the second World War – telephonists - which I

rejected and I thought there was no way I was going to be a telephonist.”

Attitudinal oppression as described by Conley in the previous section, can have a direct influence on identity. The experience of Mark shows how this manifested itself for him in the Army;

“I did fifteen years in the army, then did an HGV course. The eye test failed me so I had to see the medical bloke and he said ‘You should be walking round with a white stick’, that’s how blunt he was. I thought ‘fair enough, what’s the treatment?’, ‘there isn’t any’, simple as that. The last five years in the army, I started to be downgraded medically which messed up my postings as well as my promotion. I was still able to do my job, still fit, but their policy was you had to be Class 1. I’d reached full corporal and qualified up to sergeant but I couldn’t get to that rank because I kept being downgraded more or less every year.”

It is clear from Mark's testimony that this form of discrimination cost him dearly in financial terms and also in his self-identity within the Army. Conflict was inevitable between Mark's 'virtual' identity (imposed by the Army) and his 'actual' identity (his perception of his role).

“There were a number of postings where I was doing a sergeants job and only getting paid as a corporal. I was capable of doing the sergeants job, taking on the responsibilities but not getting the recognition for it. It was a bit unfair 'cos the way I see it, regardless of who you are and what you are, if you can do the job you should be allowed to do it and have the recognition for it. I was the most qualified corporal in the unit. I was passed over for promotion every year.”

Chapter 2 detailed Bury's theory of *biographical disruption* and the three predicaments facing an individual with an impairment. These are equally relevant to employment. The impact of disruption and the struggle to adapt and reformulate life is illustrated by the statement given by Dave

“When something like that happens, you make plans. I was going to go to the Philippines to recruit someone to look after me in Saudi, a housekeeper, driver and assistant at work”.

### Rehabilitation and the Medical/Social Theories of Disability

Hyde (2000:337-8) describes the stark choice facing disabled people in the post war era of the United Kingdom. The options of “welfare’ or ‘work’ as it has been framed by governments...is unnecessarily restricted, and neither option is likely to be satisfactory.”

Hyde states that “an exclusive focus on social security is insufficient because it fails to address the underlying causes of social exclusion”.

UPIAS (Union of The Physically Impaired Against Segregation) condemn an approach which is based on income,

“The particular form of poverty principally associated with...impairment is caused by our exclusion from the ability to earn an income on a

par with our able-bodied peers, due to the way  
employment is arranged” (1976:14)

The medical theory of disability “explains economic disadvantage in terms of individual impairment” (Hyde 2000:338) and this in turn drives the emphasis on people to adapt to “the needs of employers by requiring them to participate in rehabilitation, training and jobsearch activities”. However, the social model “explains economic disadvantage in terms of the organisation of society including its main institutions, values and customs” (Hyde 2000:338).

Morris (1989) and Seymour (1998:21) in Barnes and Mercer (2003:16) give voice to the notion that the drive for rehabilitation is based on the premise of what bodies should be in form and function. “There is a determination to fit the disabled person back into society, and thereby achieve a ‘good result’”. The ‘advances’ in science and technology may mean that bodies can be repaired or ‘improved upon’ but, in the enthusiasm to show what can be done, move far beyond the question of why it is desirable. This question requires deep consideration of the implications of reconstruction. Does scientific potential help perpetuate the myth of designer bodies along with the ‘beauty’ industries and cosmetic surgery?

The medical theory of disability with its “dominant sociological approaches to ‘chronic illness and disability’” (Barnes & Mercer 2003:7) sites disability within the individual’s impairment. The emphasis on rehabilitation and training for people with impairments in order that they may best be able to re-enter society as a ‘normal’ functioning, productive person appears to support this model. The individual, rather than society, is required to adapt and change.

“Within rehabilitation, the environment has been defined for the most part as a physical phenomenon, a set of discrete obstacles or barriers, which add to and amplify the problems of impairment afflicting individuals”,

reflecting the medical model as opposed to,

“The sociological study of chronic illness and disability has tended to define the environment as something arising out of the symbolic and social interaction that takes place between individuals and their worlds as they negotiate their everyday lives”.

(Williams (1996:195)

Each of the participants in this study has undertaken some degree of rehabilitation and training with St Dunstons. This training has been funded by public donations which in itself offers an interesting conundrum. The stated aim of rehabilitation and training is to promote independence for the individual with the ultimate goal being that of future employment. However, in order to raise the necessary money to finance this operation, the charity uses promotional material which depicts soldiers from the first World War, eyes bandaged and following each other, hands on shoulders, away from the front line and also paintings by R Canton Woodville (St Dunstons 1995). The dilemma is clear; in order to persuade the public to part with their money a message must be delivered that has emotional impact. The sympathy vote. With statutory organisations at full stretch financially there is an ever-growing role for charitable organisations but this also means greater competition for funds. Therefore, each charity must compete to produce a message of greater impact. The emotive tags that are widely used are pity and guilt. This negative imagery only serves to reinforce the 'disabled identity' as one of pain, suffering and tragedy.

“By creating a passive, tragic, dependent image of us, the charities have been able to build their empires. By setting up individual, medical condition

charities...and by using harrowing pictures of us plastered on billboards, they are able to raise the cash to build more segregated schools, homes and workshops which, in turn, maintain our image of dependency on them.” (Campbell in Morris 1991:110)

By maintaining the emphasis on the individual trauma of impairment, charities have to accept some of the responsibility for perpetuating the medical theory of disability.

Chapter 5 looked at the issues pertaining to employment from the perspective of disabled people generally and specifically for people with a visual impairment. It addressed the role of employment in relation to identity and explored the manifestation of discrimination from the medical and social theory angles. Rehabilitation and training are recurring themes in societal attitudes towards impairment and work and these were examined together with their connections to charities, St Dunstons in particular. The next chapter moves from the workplace to social interaction.

## Chapter 6 – A New Social Life?

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The previous chapter focussed on the working environment and the experiences of disabled people illustrated by the biographical detail from the study participants. This chapter concentrates upon social interaction in a wider sense whether it is within close family relationships, larger, familiar groups or the community as a whole.

### Social Interaction

I have taken the term social life to mean, not just the restrictive area of leisure pursuits, but the wider context of social interaction wherever it may take place. The following quote is used to exemplify the difficulties experienced by disabled people and their interaction with society.

“...stereotypical constructions of disabled people as having ‘something wrong with them’ based on reports of impairment, specific medical treatments and triumph-over-tragedy stories continue to dominate the coverage of disability issues...This undervalues disabled people’s contribution to society and reinforces the misguided assumption

that all disabled people have a medical 'problem' which prevents them from participating in the mainstream economic and social life of the community" (Oliver and Barnes 1998:65)

Reeve (2002:10) reports that a study by Grewal, et al., in 2002 illustrated that over 50% of people with impairments did not see themselves as disabled. This arose for a number of reasons; either they did not regard their impairment as severe enough, their impairment was part of the natural process of ageing or that the "negative images associated with disability caused some participants to be too embarrassed to identify as disabled". It also emerged that disability was firmly linked with mobility "was visible, led to dependency and incapacity and was a permanent condition" (Reeve 2002:11). This leads us to the conundrum where "whilst having an impairment is an essential characteristic for someone to be able to identify as disabled, the presence of the former does not always lead to the latter" (Reeve 2002:11). It is therefore impossible for all people who *do* identify as being disabled to share a common identity. "The issue of who identifies themselves as disabled, or who is seen as disabled by others is not simple and clear-cut" (Watson 2002 in Reeve 2002:11). People with less

noticeable or visible impairments may be less likely to regard themselves as disabled and their interaction with society may be less obstructed. The attempts by disabled people to enjoy an active social life are hindered not only by the physical barriers that they encounter but also the reactions of other people within society. This is borne out by Mark's experience;

“I was at the NEC last weekend with my son. I had my white cane with me and I was talking to a girl on a stall and it really annoyed me because she didn't look at me and talk to me, she spoke to my son. I think there's a lack of understanding, they don't realise that just because we're blind that doesn't mean we can't do nothing.”

Chuinard (in Reeve 2002:5) suggests that

“non-disabled people may feel that they have the right to ask these kinds of personal questions because disabled people are occupying 'their' public space, and like children and elderly people, can be approached with less respect and reserve than the average adult”.

Non-disabled society has expectations of the image of disability and this can become a form of aggression if a disabled person fails to 'live up to' the identity that has been imposed in order that society can match the individual to their 'identikit' image. A blind person does not *always* wear dark glasses or use a guide dog and yet, even within a society where ignorance would not be expected, it can be clearly demonstrated. St Dunstons exists solely for men and women who have a significant sight loss and it might be expected that each individual would have an understanding of another persons situation. In actuality there exist various sub-groups and divisions according to the degree of residual vision each person is *believed* to have by other factions. The identity of being blind is jealously fought over and it is commonplace to hear references to another's ability to see and therefore their invalidity to be regarded as blind. This phenomenon is similar to that referred to by Reeve (2002:12) where people with impairments "who do pass can be seen as traitors by others within the disabled people's movement" except that here the outrage is directed at people who are identifying themselves as disabled by people with the same impairment who identify *themselves* as being *more* disabled.

"When I first went there (*St Dunstons Ovingdean Centre*) some of the older boys said I wasn't a real

St Dunstaner...I could see a bit and some of them  
couldn't see at all. I was a fraud according to  
them...there was some aggravation”

This was Mark's experience when he stayed at Ovingdean for  
rehabilitation. It was clear to him that the ex-servicemen from earlier  
conflicts drew a distinction between their experiences and their authenticity  
as blinded ex-servicemen and those experiences of servicemen who lost  
their sight through other causes.

In Goffman (1963:19-20), where a person with an impairment is identified  
as having a 'stigma' (as discussed in Chapter 4), that individual may  
respond by making “a direct attempt to correct what he sees as the  
objective basis of his failing, as when a physically deformed person  
undergoes plastic surgery, a blind person eye treatment...” Goffman states  
that where such “repair” is possible then the individual does not gain, or  
regain, “fully normal status” but that of “someone with a record of having  
corrected a particular blemish”. Other attempts by an individual to “correct  
his condition” may be the “mastery of areas of activity ordinarily felt to be  
closed on incidental and physical grounds to one with his shortcoming”.  
The “stigmatised individual” may be unsure of his/her reception by society,  
of what identity society will bequeath. This is especially so for people with

a visual impairment who do not have access to the unspoken information given by facial expressions or body language. The individual may feel that “he is ‘on’, having to be self-conscious and calculating about the impression he is making, to a degree and in areas of conduct which he assumes others are not” (Goffman 1963:25).

“His once most ordinary deeds – walking nonchalantly up the street, locating peas on his plate, lighting a cigarette – are no longer ordinary. He becomes an unusual person. If he performs them with finesse and assurance they excite the same kind of wonderment inspired by a magician who pulls rabbits out of hats”. (Goffman 1963:26)

The medical model of disability, with its emphasis on ‘personal tragedy’ can lead the individual to believe “that if he adopts the right line (which line depending on who is talking), he will have come to terms with himself and be a whole man; he will be an adult with dignity and self-respect” (Goffman 1963:149). This requires the individual to assume an identity which fits in with the perceptions of whichever group he is in at that point in time. Morris (1991:117) describes how society’s reactions to physical and intellectual difference, and the needs created by those differences, impact

on how disabled people experience life. Those reactions have power over where disabled people live, how they are educated, employment opportunities, access to leisure and even whether they can have sexual relationships, friends or children. “This disabilism, this prejudice, compounded of fear and ignorance, is an important determination of our social, economic and personal experiences”.

Tom illustrates this point when he describes the alienation he experienced;

“People’s attitudes towards me changed...the Navy’s quite caring, we’re all quite close and intimate and the bonds made were strong but it sorted out the people you thought were genuine friends, some melted away, they couldn’t deal with it...my marriage was wrecked because everything suddenly changed. My current wife took me as I am and we’re pretty good.”

Disabled people are subjected to segregation through their separation from mainstream society. This segregation through environmental or attitudinal barriers is highlighted by John;

“There’s always barriers to everything that you wish to do. There’s the obvious barriers that you can’t do

what you want to do. You can't drive a fast car if your eyes don't work, that's a barrier that you can't argue with but there are also barriers that people build. You get some people, I guess you'd call them control freaks, demonstrating the bit of control they have."

The existence of structural and psycho-emotional dimensions of disability can make it extremely difficult for people with impairments to involve themselves within mainstream society.

"Going out in public so often takes courage. How many of us find that we can't dredge up the strength to do it day after day...a lifetime of rejection and revulsion? It is not only physical limitations that restrict us to our homes and those whom we know. It is the knowledge that each entry into the public world will be dominated by stares, by condescension, by pity and by hostility". (Morris 1991:25)

Morris refers to Sandra Lambert's experience of psycho-emotional oppression "I pretend to forget how deeply disabled people are hated. I

pretend to forget how this is true even within my chosen home...My survival at every level depends on maintaining good relationships with able-bodied people” (1991:26).

Exclusion from the non-disabled world is constantly reinforced,

“For those with restricted mobility or sensory disabilities, the very physical environment tells us we don’t belong. It tells us that we aren’t wanted in the places that non-disabled people spend their lives – their homes, their schools and colleges, their workplaces, their leisure venues...The refusal to give Braille the same status as printed material shuts out people with a visual impairment.” (Morris 1991:26/7)

Dave gives his insight on this phenomenon,

“All my life I’ve had this front, had this brick wall and I’m very confident in what I do but I have very little self-confidence in the social side and that was hammered. People definitely see me as blind rather than a person. I’m very independent, I always have been, I’m a bit of an outsider in that sense so I walk

around as I want to walk around except I wear dark glasses 'cos I'm photophobic. People think I'm posing but then, when I produce a symbol cane, they say 'oh, I didn't know you were blind'. People can be very aggressive, 'what do you expect me to do if you don't use a white cane?' and I've said 'what do you want me to do, walk around with a label stuck on my head?' That upsets me, that really annoys me. Why should I walk around with a cane when I don't need it? Just so other people can feel comfortable."

Cultural representations of disabled people tend not to focus on their lives but offer insight into societal attitudes towards disability.

"Disability is used as a metaphor, as a code, for the message that the non-disabled writer wishes to get across, in the same way that 'beauty' is used. In doing this, the writer draws on the prejudice, ignorance and fear that generally exist towards disabled people..." (Morris 1991:93).

Shilling (1993:3) describes the “massive rise of the body in consumer culture as a bearer of symbolic value... there is a tendency for people in high modernity to place ever more importance on the body as constitutive of self”. However, a shift of focus on the body from the perspective of power to the biographical experience “provides a path to understanding agency and identity” (Hughes and Peterson in Barnes & Mercer 2003:18). Morris makes references that are particularly relevant to this study in that she notes the more recent use of disability and disabled men as “a metaphor for dependence and lack of autonomy”. (1991:93)

Goffman (1963:153) describes the American picture of man as “a young, married, white, urban, northern, heterosexual Protestant father of college education, fully employed, of good complexion, weight and height and a recent record in sports”. This view is widely held throughout Western culture and any male who fails this catalogue in any way is likely to feel “unworthy, incomplete and inferior”.

The participants in this research have come from a very male-orientated background, in a career where the characteristics that society recognises as masculine (physical strength, unemotional, independent) are valued and developed further. “The social definition of masculinity is inextricably bound up with a celebration of strength, of perfect bodies. At the same

time, to be masculine is to be not vulnerable". (Morris 1991:93) Morris illustrates this phenomenon with a description of the programme made by the BBC, *Tumbledown*, which depicted a soldier injured in the Falklands war and which "(inadvertently) exposed the cultural representation of ability and disability" (Morris 1991:93). As in the film, the armed forces strive for, and offer physical strength and perfection, how then are servicemen equipped to deal with anything less than that. The representation of disabled men as dependent and impotent is compounded in *My Left Foot* and *Born on the Fourth of July* both of which depict men with impairments as lacking in power in their lives and humiliated by the loss of independence. In each film, the main character experiences loss in his life, whether career or relationship, and his reaction to these life events is seen as atypical behaviour for a disabled person; they are not expected to react to trauma as a 'normal' person. Similarly, both characters are impotent, reinforcing the attitude that to be valid a man must be heterosexual. There is evidence from the testimony of Roy that shows that not only must a man be perceived by society to portray those characteristics (deemed by society) to confer masculinity but he must also repress any emotions which convey negativity;

“I think twice about losing my temper because no-one wants to help you. Sometimes you’d like to say something but you can’t because of the help you need.”

Comparisons can be drawn between the concept of economic dependency experienced by women who are perceived as helpless and subordinate to the experience of dependency of a blinded soldier. The needs of a disabled man will also translate into helplessness through the assumptions made by society that those needs are generated solely by his physical limitations. Watson (1998:150) illustrates this by using the analysis of masculinity and physical disability by Gershick and Miller (1995) which highlights the untenable position of disabled men. “A disabled man is not able to conform to the cultural demands of masculinity and gender identity, yet to be accepted within society he must have an appropriate gender identity”.

Reeve (2002:5) described another facet of psycho-emotional disablism as “the experience of being stared at” which can leave disabled people “feeling ashamed, vulnerable and invalidated”. However, as mentioned previously in this chapter, not all blind people have the trappings of blindness that society expects. Therefore, they may not experience the

phenomenon of being exposed to public gaze but may, instead, experience “the risk that their disability status will be revealed and this fear forms the basis for ‘the negative psycho-emotional aspects of concealment’” (Thomas 1991:55 in Reeve 2002:6).

The damage caused to a disabled person’s psycho-emotional health by society’s response to that person’s desire to have a fulfilling social life can result in what is perhaps the most disabling of all, internalised oppression.

John’s testimony described how

“my friends who I’ve had since before I was in the forces don’t treat me differently, they know I’d hate that,” but “people who don’t know me treat me differently but I guess that’s to be expected.”

Here, internalised oppression has created an expectancy of how John believes he will be accommodated by society.

The language that we use, the stereotypes the society produces and the lack of positive images in peer groups can reinforce the prejudices held by society so that disabled people believe in the myth creating feelings of disempowerment and negativity. This in turn can produce the image of disabled people that society anticipates thus providing a self-fulfilling prophecy.

In his interview, Dave reported that;

“It’s definitely the attitudes of other people that cause me most problems. It’s totally the attitude. I’m happier now, I rarely go out. With my sight gone, I can’t tell what people are thinking, I’ve no body language input or facial input and that means a lot... I’m quite happy sitting here with a few cans and the television, it’s my window on the world. By sitting right up to the screen I can see features, I can’t walk up to someone on the street and put my face in theirs. It’s not socially acceptable.”

Reeve (2002:8) describes internalised oppression as “one of the most important manifestations of psycho-emotional disablism because of its unconscious and insidious effects on the psycho-emotional well-being of disabled people and because it has a direct impact restricting who someone can ‘be’.” In the interview with Roy, the effects of internalised oppression became apparent;

“You’ve got to be careful how you put yourself over as a blind person. They would pick you up as being the most miserable blind person they’d ever met.

You've always got to be on your toes to present yourself well. You present a kind of image of yourself whereas before, when I was sighted, it just came natural. But now I have to really think how to present myself wherever I go. There is a kind of pressure to present an image that people will accept. You can't have a bad day because people will think you're a grumpy blind person."

"Our sense of self has a past and also an anticipated future" (Watson 1998:148) and in modern culture we are expected to take responsibility for the creation of our own identity. Along with this responsibility comes the growing ideal of self-reliance, of independence. "It is only by being independent that we can truly forge our sense of self, our own identity. People who are not seen as being independent are in some way lacking: independence is seen as integral to our acceptance as responsible adults" (Watson 1998:148). Mark supports this statement when he reports,

"Because we're disabled we're see as a burden on society, 'why should we include you workwise or socially?' That's how I see it. People need

educating so that they can understand, yes, we're disabled but we've got some brain up here."

As stated by Morris (1991:28) "The messages we receive are very strong and clear and we have little access to different values which may place a more positive value on our bodies, ourselves and our lives. Our self image is thus dominated by the non-disabled world's reaction to us".

This statement is supported by the evidence from Tom;

"I noticed in my earlier long cane days that, if I walked purposefully, there was no problem but if I stopped and looked confused people came to help. There must be a message that you give out. People used to ask me how I lost my sight but these days, on trains for example, it's just a normal conversation. So I'm giving off different messages. Maybe I don't let it come into the conversation, maybe I take charge of the situation. The conversation doesn't centre on blindness, it could be last night's football game."

Tom believes that the image he presents causes society to react to him as a 'normal' man. This is, however, a much more complex issue. It is difficult

to measure whether society's attitudes have, in fact, moved towards a position more in keeping with the social theory of disability or whether Tom is 'passing' and thereby attempting to make himself 'acceptable'. These short term relationships with strangers allow for "control of identity information" (Goffman 1963:108) "the more time the individual spends with another the more chance the other will acquire discrediting information about him."

Sale's article (2001) as discussed in Chapter 2 describes ex-servicemen as vulnerable having lost the cocooning environment of the forces where they were given a regimented, institutionalised life. Life away from this sheltered existence left the ex-soldier alone to make decisions and take responsibility for themselves as to where they lived, what job they held. This, according to Sale, contributed to the number servicemen among homeless and unemployed people. John supports this in some measure;

"It's been a very big change and I like to feel that I've adapted pretty well but some people occasionally tell me I haven't that well. Some of the time I do pig people off and my wife will tell me every now and then "You're not in the army now".

Another facet to this discussion is the apparent willingness of John to immerse himself into another form of institution;

“At the day centre they’re quite experienced and it’s run by medical staff, they do understand people’s disabilities.”

Perhaps this indicates that the type of personality that thrives in the controlled life of the forces will look for this regulation in their life at other periods.

### Personal Relationships

In the last section Tom made an observation regarding the breakdown of his marriage, illustrating the impact of impairment upon close relationships. Of the six participants in this study, only one, Carl, retained the relationship with his partner after the incident which took his sight. This is despite the fact that he himself no longer believed that he was a worthwhile proposition as husband and father.

“I was visited every day and night by my wife. I asked her ‘if she wanted to leave, she could’ as she never married a blind man, with that she told me something that isn’t printable and said this is for

better or worse...it was only then I realised what I had. If there was a time I should have cried it was then.”

The pressure on close relationships to a change in circumstances may not come from within the relationship itself, it may come from external sources. In his testimony, Tom refers to the oppression experienced by his wife;

“There is a penalty for this public façade (his job), because my wife sees them looking. I don’t know if I could do the job if I could see, I just tend to block it off.”

This links to Goffmans theories on associated stigma for family and friends. Goffman refers to individuals who are related to a stigmatised person as being “obliged to share some of the discredit of the stigmatised person to whom they are related.” (1963:43) Goffman continues with his observation that “the tendency for a stigma to spread from the stigmatised individual to his close connections provides a reason why such relations tend either to be avoided or to be terminated, where existing.” Indeed, of the six interviewees, three report the breakdown of their marriages as a direct consequence of their sight impairment and each of the six reports that friendships that they thought were close, have foundered.

“It contributed to the deterioration in my marriage.

She didn’t really say anything, she didn’t discuss it with me, probably because I didn’t discuss it.”

(Mark)

It is not possible to prove that the marriages or friendships failed solely due to the experience of ‘courtesy stigmatisation’. However, given our powerful human need for an acceptable social identity it is highly likely that this must have an effect.

Mark, Roy and Tom have all had lasting relationships with the women that they married after their sight loss.

“My first wife left me because of my sight loss...at first I wouldn’t trust anyone but then I met Carol (*pseudonym*) and she was more upfront and helpful. I had a lot of confidence in her.”

Roy describes here the difficulties he had in building a new relationship after the breakdown of his first marriage. It is an example of what Michalko refers to as an “identity crossing”. These experiences occur throughout our lives,

“We expect that we will take some of these crossings, such as crossing over into adulthood,

and we wait on the threshold preparing for our first step into a new identity. But there are other identities for which we do not wait and into whose province we do not expect to traverse. Some make us shudder when we think of them as a possibility and we dismiss such thoughts from our minds as quickly as possible. Disability is one such identity.”

(Michalko 2002:77)

This chapter has examined the barriers to social interaction experienced by disabled people. These barriers may arise from attitudes within society generally that are reinforced by cultural representation. They may also be formed by internalised oppression, perhaps the most disabling factor of all. It is clear that relationships at all levels are affected by an acquired impairment and that the reasons for this are complex.

## Chapter 7 – Summary

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The aim of this dissertation was to apply a social model perspective to the lives of blind ex-servicemen. This was to be achieved through contrasting the theoretical viewpoints with the personal testimonies of six blind ex-servicemen. Access to these men's' stories was made possible by their membership of St Dunstons, which employs me a Welfare Officer.

From the context of an interpretive paradigm and with a desire for a qualitative study, a semi-structured style of interview was chosen to give structure as well as the freedom to expand into areas of interest to the participants. This method proved to be successful in gathering data but there was room for improvement. As the participants had no prior knowledge of the social or medical models of disability their responses to the questions were, sometimes, not totally relevant to the subject. It would have been more appropriate to have held pre-interview talks to describe the background to the study in more detail. The interviews were quite lengthy and involved considerable work in transcribing and identifying useful material. On assimilating the data from the interviews it became clear that it would have been beneficial to conduct further interviews, possibly in a group setting. This small group of people discussing a

common experience could have raised issues that did not occur singularly. However, with time constraints and the necessity to travel long distances, this was not possible.

Chapter 2 looked at the theoretical models of disability, social and medical, and theoretical studies of identity formation and the experience of sight loss. It discussed the mechanisms by which an individual adjusts to an acquired impairment with reference to Bury's work on biographical disruption and Shakespeare on the impact of impairment and disability on identity. The experience of sight loss is regarded from the institutional/organisational stance of the RNIB and St Dunstons and also from the personal point of view. Identity formation is discussed as a general issue and then linked more specifically to servicemen.

Chapter 3 on the hows, whys and wherefores of data collection for this study introduced the debate regarding the social model and its in/ability to address individual experience, suggesting the extended social model as a possible move forward.

Chapters 4,5 and 6 focussed in more detail on the issues of identity formation (as introduced in Chapter 2) and the arenas of employment and social interaction which are fundamental aspects of Western culture. The

theoretical information is interwoven with the information offered by the study participants.

It is clear from the testimonies that each of the participants has a perception of what constitutes the identity of a blind person. It is equally clear that none of the six subscribe to this identity and view themselves as individual rather than part of an identifiable group.

Roy and Tom's testimonies in Chapter 4 give insight into the impact of an acquired sight impairment; the shock, the loss of independence and the denial. After the initial impact, each of the participants displayed a enthusiasm to move forwards with life in a determined, confident manner undeterred by their change in circumstances. Perhaps this positive mental attitude comes from character and it is people of a particular 'type' or with a certain set of personal traits that seek careers in the armed forces.

Although the information given shows that the six men refute their 'disabled identity' this is contradicted by the way in which they have actively sought out people in a similar position for social interaction either through St Dunstons or in their localities.

Without exception, social attitudes were deemed to be the greatest oppressive factor. This oppression attempted to impose an identity that none of the six believed fitted their self-perception.

This attitudinal discrimination is evident in the workplace and in social interaction. None of the participants were given appropriate support by their employers in finding suitable work post sight loss. Some were summarily discharged on medical grounds and those treated less harshly were left to determine their own options which lead inexorably to employment outside the military. And so, along with sight loss, came loss of identity as part of a particularly masculine organisation.

Another aspect of identity which sustained a major impact was that of relationships. Only one of the participants continued in the relationship he was in at the point of sight loss. The other five reported the breakdown of close relationships with partners, wives and friends and always at the instigation of the other person. However, each has formed new close relationships and marriages. It would appear that, although the men themselves did not feel that they had changed, their existing relationships were based on their former identities as sighted soldiers, as perceived by the other people in their lives.

An experience that came across strongly from this group was that of having to project an acceptable image. Portraying any kind of negative emotions such as anger or frustration would be attributed with their impairment and not to the individual as a person.

In conclusion, it must be seen that the social theory of disability has great relevance to the lives of blind ex-servicemen. This is evident in the discriminatory practices that each participant has experienced. It is also apparent in the identity that society has assigned to them. It is the repressive nature of this attitudinal discrimination that engenders internalised oppression. This indicates that the extended social model which encompasses psycho-emotional oppression, has to be viewed as equally relevant and possibly a better tool for evaluating the experiences of blind ex-servicemen.

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## Appendix 1 – the Participants

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### **Participant 1 – J**

John (aged 33) joined the Royal Airforce at the age of 18 and served as an Air Traffic Controller in the Gulf War as well as in Canada, USA, Cyprus and North-West Europe. He was medically discharged in 1997 following the diagnosis of Multiple Sclerosis. He is registered blind and uses a wheelchair.

### **Participant 2 – M**

M (aged 45) joined the Royal Army Ordnance Corps on leaving school at the age of 16 following in his father's footsteps. He trained as a Combat Supply Specialist and was medically discharged in 1988 following diagnosis of Retinitis Pigmentosa.

### **Participant 3 – R**

R (aged 58) enlisted in the Army at the age of 18. In 1973 while serving in Northern Ireland he was blown up by a bomb and experienced injuries to his face and hands resulting in sight impairment, damage to his mouth and shrapnel embedded in his face and hands. He was medically discharged in the same year.

### **Participant 4 – C**

C (aged 29) enlisted in the Army at the age of 16. It had always been his ambition to be a soldier. In 2000 he was injured by another soldier resulting in total loss of sight. He was medically discharged in 2002.

### **Participant 5 – D**

D (aged 52) joined the Royal Navy in 1968 having left home at the age of 14 with little idea of what he would do for a career. He served on submarines until 1981. Following his discharge, he worked for Saudi

Airlines until he acquired sight impairment through geographical choroidopathy.

### **Participant 6 – T**

T (aged 59) enlisted in the Royal Navy in 1960. His father had served in the Navy and it was T's from an early age to do the same. He was serving on HMS Antrim during the Falklands when he was injured by aircraft fire. His sight loss was total and instant.