Bypassing the Perils of Victimisation: A Suggested Future Pathway for Disability Studies

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Abstract: Current trends in Disability Studies hint at an overemphasis on the social model. Much description and analysis has been devoted to the dimensions of stigmatisation—how and why people with a disability are a disadvantaged social minority. While this is important, it can exacerbate victimisation in political and personal domains. This article scrutinises victimisation in disability thought and suggests ways to bypass the perils of victimisation. The article focuses on psychosocial implications of disability and, above all, suggests prescriptive measures—something rarely mentioned in disability thought.

Key Words: Disability Studies, Social Model, Reflexive Sociology

Introduction

There is a dearth of knowledge in disability studies. This intellectual void concerns maximising psychosocial potential of people with a disability. At present we have a sound and comprehensive understanding of social dynamics and structures prohibiting access to society. The social model has enabled this through extensive epistemological description and analysis. It has shown how and why ableism is prevalent. But little academic investigation has been allocated to how people with a disability can maximise their potential in a personal domain. As a theoretical critique, this paper attempts to show why this is so. Additionally, it suggests prescriptive measures by advocating epistemological innovation in Disability Studies – psychosocial potential maximisation. The article is divided into three parts; description, analysis and prescription. It begins as a sociological study–to describe and analyse–then funnels into micro-sociological thought–the prescriptive element.

Description: Stigmatisation, the Glass Sphere and Victimisation

Feminist Ann Morrison coined the term the "glass ceiling" in 1987. She identified the glass ceiling as the invisible barrier preventing women and people from minority groups from attaining exclusive management jobs in commercial organizations (Code, 2000). In feminist thought, the concept also refers to a point or rung in the organization's hierarchy where women cannot go further. It is an artificial social barrier created by the historical premise that males are more competent and deserving of status than are females. Men with the same qualifications and abilities or less are given preference over women on the basis of their gender. The glass, a transparent barrier, is metaphorical. Women can see beyond but are prevented entry by the glass ceiling.

People with a disability face a similar situation. The "glass sphere" is a figurative representation whereby a person with a disability can see through the surrounding glass and others can see the person inside the sphere (Jacobs, 2003). Untouchable and unreachable by others, the outside world is inaccessible to the person within. This sphere is by no means an illusion and has two defining themes. The first is the stranger-to-

stranger dynamic that is a common characteristic of traditional relationships whereby people act in "roles" ascribed to them (Giddens, 1996; Kopp, 1971). Traditional communities, which still exist and function worldwide, are mechanical solidarities whereby the power of the state and/or religion are paramount and function best with the stringent allocation and conditional interplay of roles. There is a tendency to denounce, or even eradicate, individual autonomy. Pressure toward conformity is another inherent human trait (Giddens, 1996). Human character is deemed unalterable and fixed, and certainly not something that can be improved or maximized (Seligman, 1994). In these social circumstances, the person with a disability has little choice but to "be disabled" for the non-disabled person (or who Ervin Goffman [1963] often refers to as "we normals") and thinking and interaction is dictated by stigma. Martin Seligman (1994) believes the evolution from the entrenched belief in the unchangability of human nature towards its opposite of human autonomy is relatively recent. Self-identity has become a psychological rather than a social construction whereby people assume roles that are simply inherited or predetermined by status (Giddens, 1996). This concept of identity generates a politic where the self, and increasingly the body also, operate as a reflexive project. To determine the health of ones lifestyle, a "person's identity has in large part to be discovered, constructed and actively sustained" (Giddens, 1996, p. 82; Jacobs, 2002, p. 63). This implies people have control over their destiny and presumes a close tie between individual autonomy and lifestyle. The second major influence on the glass sphere is more complex and relates to individual autonomy. Since the glass sphere caused by their disability separates them, the person is in many ways exempt from responsibility for personal well being, which is a natural condition of everyday living that generates psychosocial competence (Csikszentmihalyi, 1992; Namka, 1989). This will be explored later in this article.

The glass sphere is perhaps a more debilitating condition than the glass ceiling. At least with the ceiling there is interaction and "touching" with others beneath it. Nevertheless, the glass sphere is of particular relevance to disability. The glass is hardened by the outside incurrence of stigmatisation and can be perpetuated by the victimisation of the person within. Little or nothing is done and the person remains fixed in the glass sphere. Goffman (1997, p. 205) explains:

"By definition ... we [*sic*] believe a person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his [*sic*] life chances. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalising an animosity based on other differences…"

Goffman identifies three contributors responsible for the existence of the glass sphere. Firstly, the person with a disability is deemed subhuman, even animal-like; secondly, the process of stigmatisation is often a subconscious rather than conscious act on the part of "normals", and finally, deviance is often legitimized.

Stigmatisation, however, is not exclusively an externally imposed phenomenon. Through shame and guilt, the disabled person is often forced into the stranger versus stranger social dynamic. Shame, stated Goffman (1997, p. 206), arises "from the individual's perception of one of his [*sic*] own attributes as being a defiling thing to

possess, and one he can readily see himself as not possessing." For the disabled person it could be the perceived advantages of being able bodied. Guilt originates in the realisation that we or, more specifically, our behaviour is deviant and/or transgresses the bounds of social norms – something that is apt to cause anxiety. Anthony Giddens (1996, p. 68) claimed that this may also derive "from a failure to live up to expectations of the ego-ideal." This goes beyond simply wishing to "lose" ones disability to having the ability to function with greater ease in social circles. Nevertheless, the notions of shame and guilt hint at the internally driven socio-cognitive processes that harden the glass sphere. These phenomena lead us to victimisation.

Victimisation

The term "victimisation" is commonly known as the context where a person or group is victimized because they are socially disadvantaged. This paper views victimisation as a mindset. Usually, stigmatisation precedes victimisation because stigmatisation is largely a macro-sociological concept and victimisation is primarily micro-sociological. Although two separate theoretical entities, both stigmatisation and victimisation operate through an oppressor/oppressed binary. Stigmatisation is the creation of a social victim through labels, stereotypes and discrimination. Victimisation is self-generated, whether in a personal or group domain. This circumstance is primarily the acceptance of stigma by a social victim who manipulates their inferior social status for perceived gain. This manipulation may perpetrate socially unaccepted behaviour and an endless cycle of desperation–a situation for which victims often blame others or society because they are seldom accountable for their actions (Kopp, 1971). The serious problem is that the victim remains a stranger to a stranger by choice. They sidestep genuine interaction or feelings for ready-made responses (Jacobs, 2002). Sheldon Kopp (1971, p. 117) said this can be "accomplished through threat, flattery or pathetic appeal" – forms of emotional blackmail or bribery. The denial of personal accountability can reinforce traditional perceptions of the disabled as incapable of making life choices and as "dependent, passive, helpless, and childlike because that is what is expected of them" (Coleman, 1997, p. 224). Thus, alienation is not necessarily a one-way process where a person feels expelled because of their disability. Exclusion, then, is not simply the result of stigmatisation.

Goffman (1963) stated that stigmatised or social victims tend to be fixated on their perceived weaknesses. This is the "hook" upon which the person has hung all their inadequacies, dissatisfaction, procrastination and unpleasant duties. It appears in the manufacturing of excuses to exculpate one from everyday chores and responsibilities. The hook becomes a dependency, or a psychic addiction, that provides refuge from the competition of everyday life and social accountability (Goffman, 1963). Thus, victimisation derives from a species of obsessive-compulsive behaviour–a driving uncontrolled motivational force. Obsessiveness is noted in the unwillingness to stop the negative thought processes or voicing of the same problems that have no answers (Namka, 1989). Compulsiveness is apparent in the urge to get others to play reciprocal roles (Kopp, 1971). Generated by self-pity, this desperate game requires securing a supporting response. The result is never losing but, equally, never winning–a vicious cycle that produces psychic stagnation and disillusionment (Kopp, 1971; Jacobs, 2002).

Kopp (1971) suggested the preservation of various character defenses is due to the avoidance of genuine relationships with others. Additionally, victimisation exists on the presumption that all misfortunes in one's life are a result of "fate" and that little, if nothing, can be done to remedy a low quality of life (Goffman, 1963). His/her identity changes little for it is distilled at an infantile level of psychosocial development–a point prompted by the Dalai Lama (1999, p. 181) who stated that if everyone continually treated us as infantile the result would be a person "with the mental and emotional development of veal" for it is "the very struggle of life that makes us who we are."

Victimisation, however, is not always overt manipulation of others. It may be an existence caused by resignation or overwhelming helplessness caused by too many punishments or rejections and too few rewards for toil. This may be caused by a dire lack of assistance that enables a person to maximise their psychosocial potential-something encountered by Anthony Hogan (2001) in his study of psychosocial skills for deafened adults. He interviewed 58 deaf people for his doctorate thesis and their stories emphasised the need "to move beyond deafness rather than seeking to get over it" (Hogan, 2001, p. xiv). "Seeking to get over it" intonates short-term remedies or patch up jobs. "Moving beyond" disability implies a permanent proposition with proactive lifestyle strategies. To move beyond disability as a social construct alone, it is necessary to understand psychosocial dynamics–in particular the cognitive element of victimisation. Nevertheless, the key principle remains–the individual denies themselves opportunities to develop psychosocial competencies.

The seeds of victimisation are usually planted during times of adversity. They appear in the following examples of common mistakes in thinking paraphrased from the works of behavioural therapists Bob Montgomery and Lynette Evans (1989). These have purposefully been placed in the context of disability.

<div align="center">Common Mistakes in Thinking</div>

Overgeneralising

Overgeneralising involves making concrete conclusions on the basis of random incidents. You are telling yourself that individual events are "proof" of the overall picture: "He/she rejected me because of my disability and that means everyone else thinks the same."

Black and White Thinking

Black and white thinking involves seeing things as polar opposites, this or that but never in-between. A friendship must be very good, or it is very bad. No shades of grey. Read: "People must accept my disability or else they are discriminatory."

"Who Needs Evidence?"

This mode of thinking includes making and acting on a conclusion without any real evidence: "I am a lonely person because of my disability and everyone is scared of me. That's why my future is bleak." How is this possible when you have not asked everybody, or even do have some friends?

Looking at the World through Deep Blue Glasses

This mode of thinking entails focusing steadfastly on perceived weaknesses and magnifying beyond all proportion mistakes, failures and problems. It also involves ignoring or belittling personal strengths, successes, happy times and achievements. This, for instance, may mean focusing on the negative aspects of a disability without paying heed to the competencies and abilities one has to best the disability.

Imagining the Worst

Imagining the worst means anticipating the worst possible outcome for any event. The fear is so exaggerated that it is realistically improbable, if not impossible, for the dreaded event to manifest itself. And sometimes it eventuates in self-fulfilling prophesy. Read: "I am disabled and many people with a disability are unemployed. That means I'll be unemployed for the rest of my life."

Taking Things Personally

Taking things personally includes blaming yourself for everything despite only being partly or not at all responsible. Taking things personally can also mean assuming every mistake is immediately detected and disapproved by others, and everything in this universe is immediately connected with you. It defies the logic that most people are too self-involved even to notice what you are saying or doing. Having a disability can also make one too self-conscious. This self-imposed reservation can impose dire restrictions on the ability to maximise psychosocial potential. It can cut the bud of potential friendships, prevent one from trying new experiences, taking risks to develop new competencies – all of which are stimulants of personal growth.

How does a social victim think? "Common Mistakes in Thinking" were examples of *how* people with a disability can think. The following, "Negative Thought Processes" are socio-cognitive processes devised from Montgomery & Evans' (1989) *Ten Popular Irrational Beliefs*. They are examples of *what* people with a disability can commonly think. This cognitive element shows how the metaphor of the glass sphere can be generated from within.

Ten Negative Thought Processes

1   I must be loved, at least appreciated or approved by each significant person I meet. This can stem from the common thought: "I have to prove that I am not a disabled person."

2   Since disability is often synonymous with failure, I should be completely competent, be flawless and achieve with every opportunity. Otherwise I am worthless, useless.

3   Some people are discriminatory, immoral, depraved or evil. They must be punished for this. This is particularly true of those who patronise me and wish ill on people with a disability.

4   I will never be normal and I've had enough. My life is helpless and hopeless because I have a disability.

5   Unhappiness, including mine, is the result of society's wrongs against people with a disability. Society is to blame for my plight, not me.

6   I should worry a great deal about dangerous, unpleasant or frightening things. Social wrongs always need to be righted.

7   My life is extremely hard because I have a disability. This means I am entitled to allay difficult or unpleasant tasks or problems rather than to address them. Ignore the problem and it will go away. Better safe than sorry. No one will notice and it is okay because I have a disability.

8   I have to have that stronger person in my life. I am one half of a whole, otherwise I am not a complete person. That is why having a partner makes me feel normal and not disabled.

9   I cannot do anything right because I have a disability. My history is riddled with mistakes and misfortune because I am not normal. This is the reason why I have my problem(s) now.

10   I ought to ease the suffering of others. If I do not I am a bad person.

These negative thoughts are rife with "I must," "I ought to," "I have to," and "I should". Thus we can feel the obsessive-compulsive nature of the social victim's thought processes. We can sense the anxiety evident in victimisation--the result of self-defeating cognitive processes. Stigmatisation has nothing to do with it, nor has a physical, sensory or intellectual "abnormality" for that matter. Imperatives and absolutes are disabling thought processes. They cripple able bodied "normals" and disabled people alike. Whilst these thoughts were made in the context of an individual's perceptions of the world, the concept of disability can transcend to the group realm.

Analysis: How Victimisation Can Manifest in Disability Studies

The macro sociological or political activist approach of appealing to one or many social establishments that oppress people with disabilities can be counterproductive. Political activism, stated Tom Shakespeare (1997, p. 31) "is a very powerful rhetoric device for demanding social change," because "it identifies society as the main problem for disabled people, but it says little about the experiences of disabled people"–explicitly, psychosocial experiences. Consequently, the disabled can remain exiled as a ghettoised social minority who are "considered as a separate political and social constituency" never operating on par with others (Shakespeare, 1997, p. 31).

Disability Studies has defined disability as a social construct. It shows how people with a disability transgress overarching social norms, values and beliefs. It has also

generated many positive changes that have influenced policy making and perceptions in society at large. Thus, Disability Studies shares similarities with Feminism, Gay and Lesbian suffrage and Indigenous studies. Kinship is shared in the social model. The following randomly selected quotes reflect a sentiment Disability Studies has inherited from other civil rights movements:

"The disablement lies in the construction of society, not in the physical condition of the individual" (Brisenden, 1998, p. 24).

"We are disabled by the lack of social and personal support. We are all disabled by society's barriers" (Cooper, 1997, p. 39).

"Disabled people are disabled not by the fact of their impairment, but by disabling prejudice and discrimination" (Cooper, 1997, p. 39).

Society is the problem, not me. There is a lot of truth in the statement that society "makes" a disabled person (Scott, 1969). But how much of this social phenomenon is externally imposed or internally driven? Barriers do exist, so too does discrimination and prejudice. But comments like these cast the blame onto society and can detach the individual from stigmatisation processes. They miss the crucial importance that self determinism has to play in garnering social acceptance. How? Proactive measures required for psychosocial potential maximisation–what the individual can do to negate the forces of stigmatisation and avoid the perils of victimisation–-are neglected.

The political activist impulse, in an extreme form, can mirror fundamentalist ethos apparent in other civil rights movements who use the social model. The works of Andrea Dworkin, Susan Brownmiller and Catherine McKinnon are the feminist equivalent (Paglia, 1995). Disability Studies has the potential to become a safe haven for victims to share and air personal grievances in the guise of political activism. The result could be similar to the current crisis of victimisation experienced by feminism--a concern voiced by non-conformist feminists such as Eva Cox, Helen Garner, Christine Hoff Sommers, Camille Paglia, Katie Roiphe, and Elizabeth Wurtzel. Also, we can be drawn into what feminist Eva Cox (1996, p. 80) called a "competing victim syndrome."

Mark Deal's (2003) article *Disabled People's Attitudes to Other Impairment Groups* does not specifically address the notion of competing victims. But he does speak of a hierarchy of impairments. He devotes much of the article to the perceptions of able bodied adults and children of people with disabilities, before analysing the views of people with disabilities on the same subject. He shows the exclusion of a person with dyslexia from a support group for people with disabilities and uses this notion as a thesis that can be generalised across the spectrum of disability activism. Certain disabilities have more status than others, more privilege. Individuals with these disabilities are deemed to have greater ownership of disability. There is also an unwritten rule that the greater the person's ability to assimilate into mainstream society, or the more invisible their disability, the less equal they are amongst others with a more "abnormal" disability. Hence, a person with dyslexia is less an equal than a person in a wheelchair. The anti-assimilation politics of Deaf culture is another example of political activism causing adverse affects. It is why deaf individuals, who pursue, attain and sustain relationships

with hearing peers are deemed to be "uncritically" embracing a lifestyle that betrays their deafness (Lane, 1993, p. 7). Identity politics framed in this manner can exclude valuable human resources-people who can help us move beyond the traditional perception of disability as an ontologically intolerable experience.

As suggested, the social model tends to be overly concerned with how social factors "create" a disabled person. There is a limit to how much social barriers can be deconstructed using the social model of disability. Disability, like race or gender, is not wholly the product of external or structural influences. Wheelchair friendly buildings may allow physical access for a person using a wheelchair, but the psychosocial dynamics can remain largely unaltered. The person can still be an inhabitant of a glass sphere, be socially scared and psychologically impaired. As Daniel Johns (2003) sang, "All the bridges in the world won't save you if there is no other side to cross to." "Building bridges" or pathways, which is the product of deconstructing structural barriers and the true value of the social model, is crucial. But true integration, assimilation with the mainstream, breaking out of the glass sphere, requires competence with psychosocial skills in a personal domain. Where the social model of disability places the onus on society this new way of thinking imposes responsibility on the individual. This aptitude determines the extent and quality of relationships with the "Other"–those known as "normals." Surprisingly, few disability activists have taken advantage of the proactive micro-sociological thought at our disposal –namely the works of cognitive behavioural theorists. Nor has there been a comprehensively devised intellectual framework that assists people with a disability in becoming ontologically-secure, self-actualising agents.

Disabled Heroes

Some disability theorists view psychosocial potential maximisation as problematic. They claim that the "process of adaptation" is expected of people with impairments in order to become as "normal" as possible. This pressure can be overwhelming, if not more disabling. Additionally, those who perceivably "overcome" or "eradicate" their disability are sanctified and viewed as exemplars, whereas the perceived majority who do not achieve or aspire to this idealised perception of disability are deemed lazy, pathetic and antisocial. Susan Wendell (1997, p. 271) refers to the sanctified exemplars as "disabled heroes": "people with visible disabilities who receive public attention because they accomplish things that are unusual even for the able-bodied." Lennard Davis (1995, p. 10) supports this claim that the majority see the disabled as individuals without abilities, social function or status, and those who "perform successfully" somehow lose their disability. The manufacturing of "disabled heroes" creates a "feel good" factor that is comforting to the able-bodied and fuels the myth that "science will eradicate the disabled body" (Davis, 1995, p. 40). This is often perpetuated by tabloid newspapers and television citing the "miracle of medical science" for "cures." An example is the media's portrayal of people who have successfully received a cochlear implant. Those content with their deafness, and I am one, are deemed abnormal because they have not adhered to the ableist conception of eradicating their disability via a perceived medical marvel. Hence, sanctified disabled heroes can serve to increase "the 'otherness' of the majority of disabled people" (Wendell, 1997, p. 271). It is worth remembering that the disabled hero often has social, financial or physical resources

that are unusual for most people with disabilities. Abraham Maslow would argue that their basic needs have been gratified because it is precisely these support systems that have enabled them to maximize their psychosocial potential. But disabled heroes should not be dismissed on the basis of their being perceived exceptions to the rule.

Criticisms by Wendell, Davis and the like are constructed by assistance of the epistemological prism that is the social model. Whilst directed at ableist media practices, aforementioned citations by each author intonate cynicism towards "disabled heroes." This attitude can come at cost. It evokes the question: "Is it wrong for people with disabilities to maximize their psychosocial potential?" More damning still is shunning a wealth of knowledge these people can possess to negate stigmatisation and avoid the perils of victimisation. How do they do it? This is a question the social model of disability is ill-equipped to answer. Why? The telescope is on overarching macro-sociological structure. A microscope, micro-sociological investigation, is required to see how people with disabilities maximize their psychosocial potential.

Psychosocial potential maximisation could be interpreted as "becoming as normal as possible." This is a mistake. Although there is an element of normalisation, this proposed epistemology is devoid of sinister ableist notions of repairing a broken body, of denying one's disability. Where the medical model of disability is one-dimensional, psychosocial potential maximisation is multi-faceted. It involves knowing, developing and mastering as many social and psychosocial competencies as one's potential can permit. Put simply, the imperative is to purposefully seek out and continue a lifestyle that is healthy for both body and soul. This is as close as one can be to being happy (Cskszentmihalyi, 1992). Thus, normalisation is incidental and not the paramount goal. Normalisation, which comes through actively sustained and maintained interdependence, is a by-product among many.

Disability Studies has a responsibility to learn personal characteristics and lifestyle practices that increase the likelihood of living a rewarding life with all kinds of disabilities. By thinking outside the social model, taking a micro-sociological approach, "disabled heroes" may show us that living with a disability is manageable. Disability is not purely the product of ableism and can be deconstructed on a personal level. Disseminating and utilising this micro-sociological knowledge is no different than sportspeople learning and executing specialized skills to best their ability in a chosen sport. Psychosocial potential maximisation embraces all social spheres in a person's life and contributes to personal well being. Finally, investigation into proactive lifestyle skills learned from "disabled heroes" is not just for academic benefit. People whose lives are impacted by disability, ordinary citizens with a disability and their significant able bodied others, have an insatiable demand to have their needs met on a personal and interpersonal level. This brings us to the next section.

Significant Others and Researchers who are an Outsider

Each and every person with a disability has significant others in their lives. As David Wright (1993, p. 5) stated about his deafness:

> "About deafness I know everything and nothing. Everything, if forty years
> firsthand experience is to count. Nothing, when I realise the little I have to do

with the converse aspects of deafness – the other half of the dialogue. Of that side my wife knows more than I."

Disability Studies, as Jill Humphrey (2000) argued, is at a dire risk of alienating a vital resource - significant others in the lives of people with a disability. These people include partners, family members, peers, professionals and assistants who are a supporting cast in the lives of people with a disability. Disability is an extremely personalised experience. But our experience is shared, our loved ones and peers can have an affinity with disability that far exceeds our own. Our voice is not the only voice. The experience of disability is holistic, not just individualistic.

A parent of a child with cerebral palsy, providing they care and love their child, has an intimate and expert understanding of that specific disability. They have experienced the unique psychosocial processes that have occurred since the birth of their child. This knowledge is often undervalued. It is certainly under-utilised. Subsequently, future generations of parents with children who have cerebral palsy will endure the same cumbersome, painstaking process. This learning process, often a lonely one that need not be so isolating, is wrought with trial and error. One crucial problem is that the legacy of knowledge experienced by previous generations of parents is lost. There are two reasons, which can be linked to the social model. Firstly, the experience of parents who have a child with a disability is deemed less important than the experience of the disabled person. The same ideology applies to the experiences of significant others. Secondly, the psychosocial dynamics of disability have been placed a distant second to the social model in academic inquiry. Undermining psychosocial dynamics indirectly undervalues and excludes the experience and skills of significant others, able-bodied researchers and "disabled heroes".

Believing "the other half of the dialogue" of disability is vicarious at best is a fallacy (Wright, 1993, p. 5). The partner of a woman who has actively chosen a life as a non-signing deaf person in mainstream society has a specialised perception of the psychosocial dynamics specific to that phenomenon. She/he is emotionally equipped to nurture the ontological security of her/his cherished friend and lover. That intimate experience, as Wright insinuated, is not vicarious but equal with the person who has a disability. Significant others are not strangers looking in from the outside but insiders operating from within. Exclusion of able-bodied people from disability discourse for the sake of identity preservation can be counterproductive (Humphrey, 2000). Ignoring significant others, their voices and vision, defeats the purpose of understanding disability as a whole–in particular the specialised knowledge and skills of psychosocial potential maximisation that significant others can offer.

The same can be said of the able-bodied researcher. Providing their minds are stimulated, their hearts are keen and their work is meaningful, what is the problem? Yet it is naive to assume a researcher coming from another civil rights headspace can immediately slot into the disability mode of thought. A gay able-bodied researcher may have an intimate understanding of societal pressures that come with being a same sex lover. But that experience alone is not enough to adequately understand disability. I have equal credibility writing about feminist issues, as I am a white heterosexual male who has had a profound hearing impairment since the age of five. People researching disability

need to have lived with a person with a disability, to have been a significant other in a person's life.

Overreliance on the social model of disability can inadvertently package its practitioners and believers as disabled. Embracing reactive identity politics can engender navel gazing questions like, "Can a fat woman call herself disabled?" Charlotte Cooper (1997) provided a strong argument that justifies the importance of differentiating what constitutes disability. But disability need not be limited to a physical, sensory or intellectual "abnormality." The concept of disability transcends to the emotional or psychic domain-something that is outside the square of the social model.

Beyond the Social Model and Post Structuralism: Epistemological Innovation

"Rarely," wrote Fiona Campbell (2001, p. 1), "Is the matter of ontology considered a paramount concern in unpacking the ways in which a 'disabled person' is produced." Ontology concerns the psychosocial dynamics in a person's life and how they manage these dynamics. Often, people with a disability are assumed to be in an irreparable "static" emotional state. Furthermore, Campbell (2001, p. 2) states that disability "is assumed to be ontologically intolerable" and certainly not an autonomous experience. We know living with a disability need not be an ontologically intolerable experience. But, as Campbell stated, little investigation has been made into how we can master what is presumed to be an ontologically intolerable experience. We are yet to devise a comprehensive socio-cognitive processing approach in Disability Studies–to go beyond the social model as it were. That does not imply the social model is redundant. The proposed approach absorbs the social model whilst advocating and executing a psychosocial potential maximisation epistemology in Disability Studies. The social model could provide a foundation upon which a micro-sociological model can be built.

The reason why ontology has been rarely considered in disability thought could be because there has been too much description and analysis; too little prescription. Analysis and description serve mainly to provide the dimensions of stigmatisation. This is vital, but it says little about the self-generated elements of victimisation and psychosocial potential maximisation. Academically, the over-reliance on description and analysis may suggest the social model is a restricted epistemology in a disability context. Part of the problem is a strict adherence to Post Structuralist and Interpretivist thought. Post Structuralism describes an overarching belief that scientific rationality is increasingly becoming ineffective and anachronistic (Denzin & Lincoln, 1998). It connotes the replacement of empiricist thought and practice with an increased emphasis on a plurality of viewpoints (Jary & Jary, 1991). Post Structuralism is social analysis that attempts to unearth dynamics beneath surface appearances. It strives to conceptualise deeper, more "real" social structures and power dynamics (Giroux, 2001). Interpretivism, which is primarily qualitative research, entails a researchers' involvement with the researched. It empowers by connecting people otherwise not connected. The research is interactive, inclusive, dialogic and democratically esteemed rather than hierarchical, separative and categorically validated (Ferguson, Ferguson & Taylor, 1992, p. 296). Interpretivism has given voice to people with a disability, has shown that the reality of disability is distinct from the medical model and ableist conceptions of disability. Where Post Structuralism has demonstrated social structural implications, Interpretivism has

provided previously unacknowledged personalised insights. Post Structuralism is the parent epistemology of Interpretivism. In context, this helps explain that Post Structuralism is perhaps more prevalent in Disability Studies than Interpretivism.

While Post Structuralism and Interpretivism have achieved a richer understanding of disability, both are still locked in describing and analysing. Interpretivist investigation in Disability Studies is yet to comprehensively explore the vital concept of ontology and how this influences the lives of those experiencing a disability. Active participation consists of two parts to a whole. The environment is one half and the internal thought processes are the other. Prescriptive measures for psychosocial potential maximisation are required to by-pass victimisation and negate the forces of stigmatisation. This connotes equipping people with a disability and/or their significant others with emotional tools to live an ontologically productive lifestyle relative to the restrictions of disability. Interpretivism has the potential to help us understand these micro-sociological lifestyle practices. Increased focus and understanding on how people with a disability utilise their socio-cognitive skills can accelerate the deconstruction of traditional modes of disability, especially if this knowledge is disseminated, shared and practiced. Qualitative research also has the power to include the voices of significant others in disability research. Prescription is the action component of theory–a critical concept not fully utilised let alone understood in Disability Studies.

Prescription: Psychosocial Potential Maximisation

Questioning traditional modes of thought has been the first step towards detraditionalising disability. This is a sociological perspective. Actively deconstructing disabling environments on an individual level is another step. This is a psychosocial perspective. By seeing society as the sole problem we can perceive ourselves as members of an oppressed minority and not as autonomous social agents. How we think affects how we behave. How we behave determines the quality of our lives (Harvey, 1998). These are the two core concepts of cognitive behavioural therapy. Successful implementation of prescriptive measures requires incorporating cognitive behavioural theory into Disability Studies. Detailed analysis regarding the social integration of people with a disability is too comprehensive to address in this article. However, key issues could be (a) realistic expectations, (b) assertiveness training, and (c) pre-preparedness. In short, expectations relate partly to identifying situations in which the individual is more likely to maximise social interaction. Expectations also involve challenging "what you think" or "how you think"–the Belief System which will be explained shortly. Assertiveness training involves developing confidence and competence in skills that enable a person to actively and independently operate in social situations. Pre-preparedness is training in identifying possible threats and preparing oneself to deal with these social situations beforehand. These are examples of psychosocial skill training. Mastering these skills leads to psychosocial potential maximisation and a better quality of life for people with and without a disability.

Humanist psychologist Abraham Maslow is renowned for his theory of self-actualisation. Self-actualising individuals are self-sufficient people who maximize their psychosocial potential in a diverse and perpetual manner. Maslow's works cannot be condensed in one quote, but the following identifies self-actualising traits as:

"… Self-decision, self-government, being an active, responsible, self-disciplined, deciding agent rather than a pawn or helplessly 'determined' by others ... [Self-actualising people] make up their own minds, come to their own decisions, are self-starters, are responsible for themselves and their own destinies" (Maslow, 1970, p. 161).

Social destiny has direct links with psychologist Julian Rotter's (1972) notion of Locus of Control. People who believe their fate is determined by outside forces/chances have *external locus of control*–a core component of victimisation. Those with *internal locus of control* believe and demonstrate their destinies are in their control. Where people with internal locus of control consciously and autonomously maximise their psychosocial potential, those with external locus of control have not developed or utilised skills necessary to determine their quality of life–they are, and behave like, a pawn helplessly determined by others or the mythical unseen hand of fate. Numerous studies have shown "internals achieve more in school, act more independently, and feel less depressed than do externals" (Myers, 1995, p. 489). As determined by Maslow and Rotter, self-actualising individuals execute internal locus of control in their everyday dealings with the world. From this, a transition can be made into how victimisation can be by-passed via prescriptive measures for psychosocial potential maximisation. This entails changing "how you think" and "what you think."

Some people by nature appear to be successful at everything they do. Maybe they are competent with managing their thought processes, and are better able to utilize internal locus of control. The following thought maps show the mechanics of what Coleman alludes to as socio-cognitive processing. They are an elaboration of themes in Davis, Esheiman & McKay's (1982) *The Relaxation & Stress Reduction Workbook*.

$$A > C$$

"A" equals the Activating event and "C" equals the emotional Consequence/s. Simplistic thinking sees A directly causing C – outside events causing internal monologue and feelings (Bourne, 1990). This thinking is reactive, not proactive. It also suggests the presence of an external as opposed to an internal locus of control. "She said this about me, and that means I am a loser" – activating event and emotional consequence. The negative thoughts create negative consequences. What cognitive behavioural therapists do is look at the "B" – the person's Belief system – in between "A" and "C."

$$A > B > C$$

The Belief system is how you view the issue at hand. "Society is to blame, not me" is a Belief. The Ten Irrational Thought Processes are Beliefs, so too are the Ten Rational Thought Processes. It is the interpretation of the Activating event that determines the Consequence/s. A does not cause C, B causes C – beliefs cause emotional reactions (Davis, Esheiman & McKay, 1982). The role of cognitive behavioural therapists is to challenge these negative Beliefs and change them into positive Beliefs.

Following the A-B-C logic, proactive Beliefs ensure positive outcomes or emotional Consequences. A thought such as, "My life is miserable because I am stigmatised," is likely to create negative Consequences. A proactive self-actualising person is able to identify these reactive thought processes, challenge them and act upon them (Bourne, 1990). They think, "My disability is only part of who I am, but I can be friends with a diverse range of people." Thus, they are likely to create positive Consequences for themselves. Application of this to a diverse range of events may see general practices of proactive coping strategies. In all, this approach is likely to increase a person's quality of life.

The following Ten Rational Thought Processes derive from Montgomery & Evans (1989), and are rational responses to the Ten Negative Thought Processes. Again, they are placed in the context of disabilities.

Ten Rational Thought Processes

1 I have a need to be loved, liked or appreciated by some people in my life. This will not always happen. I will feel lonely and disheartened because of it. But, I can cope with these emotions. My disability need not be an obstacle to this. I can make constructive steps to pursue and maintain better relationships.

2 I want to succeed. Risk taking is never without occasional failures or periods of ill fortune, even for people without a disability. I will feel bad when this happens. But I can cope and persevere by trying better next time.

3 The world never has been and never will be a fair place, especially for disadvantaged minorities like people with a disability. Some people have done and do bad things. Upsetting myself will not change it.

4 My expectations will not always be met, but this is manageable. I can usually take constructive steps to ensure my expectations are met. But, if I cannot, exaggerating my disappointment makes things worse.

5 Factors outside my control can influence my problem(s). Prejudice and discrimination towards myself and others with a disability are real. But my present thoughts and actions can worsen the problem(s). I can control these.

6 There is a time to think about the future, but too much worry can make me unhappy. This is especially true when my disability can affect my aspirations. However, I can prepare for possible threats/problems that may or may not be directly related to my disability. That is the best anyone can do.

7 Adversity can be difficult and particularly unique because I have a disability. But I can cope with these times. Avoiding problems just gives me longer to worry about them and makes me stressed. Issues will remain.

8   Support from others when I want it is good. But eliciting pity or sympathy is destructive and offers no potential for personal growth. The person I need to rely on the most is myself.

9   Having a disability can cause troubling experiences and past events may cause current problems. But my thoughts and actions can keep them 'alive' and I have control of these.

10   It is disheartening to see others in trouble. But I cannot help them when I make myself miserable. I can manage feeling sad, and sometimes I can constructively help them.

These thoughts are proactive, not reactive. Instead of going straight from A to C, you stop at B before going to C (Davis, Esheiman & McKay, 1982). The Belief system determines the thoughts, actions and emotional consequences of a person—their ontology. It is not what happens to me but how I view it. My Belief system determines the nature of my emotional Consequences. From a disability perspective, people with a disability can actively deconstruct what it means to be disabled through positive thought processes. This is proactive, not reactive. Destiny or fate is internally as opposed to externally driven. Thus, social structures-the Post Structuralist approach to disability—have little or no part to play. Enacting positive thought processes creates constructive pathways to happiness, i.e. psychosocial potential maximisation. Social destiny is personally, as opposed to socially, determined. Hence, in an epistemological context, there is a fundamental shift from external factors to internal influences determining quality of life for people with a disability. This is the defining difference between the epistemologies of Post Structuralism and Reflexive Sociology. The latter refers to the works of Beck and Giddens (Beck, Giddens & Lash, 1997). Reflexive sociology connotes social relations that are not fixed and macro and micro-sociological realms that are mutually influential. Each shapes the other. Thus, there is the prevalent theme of individualisation—a contemporary sociological phenomenon whereby individuals increasingly "cannot rest content with an identity that is simply handed down, inherited, or built on traditional status" (Giddens, 1996, p. 192). Since the onus is on individuals, their thought processes—how they view the world and deal with it–takes on even greater importance. Hence, there is a need for Reflexive Sociology to supersede Post Structuralism as the principle research paradigm in Disability Studies.

Developed competency with the Ten Rational Thought Processes also has close ties with Jane Loevinger's (1976) "tolerance of ambiguity," which incorporates the willingness and capacity to entertain numerous perspectives of reality, not simply one's own viewpoint. Accordingly, such a person is better able to acclimate to various circumstances. They are adept in converting "entropy into a consistent flow of experience," which is not simply turning sadness into happiness, for instance, but the ability to competently manage adversity (Giddens, 1996, p. 192). They are able to go from A to C via B. Their flexible Belief system enables them to tolerate ambiguity. Conversely, a person displaying intolerance of ambiguity appears rigid in their thinking and, thus, has difficulty in managing potential threats to their worldview. Typically, they are emotionally "locked," inflexible and are usually practitioners of the Ten Negative

Thought Processes. They are stuck in an A equals C mindset. Unfortunately, intolerance of ambiguity appears commonly in studies of people who are deaf–a point made by Marschark & Spencer (2003, p. 178) who report that people who are deaf "demonstrate reduced mastery" of the conditions required for psychosocial potential maximisation "and thus are at risk for a number of adverse outcomes" —being prey to stigmatisation and victimisation. Psychosocial incompetence is not exclusively linked to deafness, but to people with all kinds of disabilities. Indirectly linking deafness with psychosocial potential maximisation are Greenberg & Kuschè's (1993) definitions of outcomes and processes required for social-emotional competence:

- Good communication skills.
- Ability to think independently.
- Aptitude for self-control and self-direction.
- Understanding the needs, feelings and motivations of others and oneself.
- Flexibility in adapting to the requirements of individual situations, and the ability to manage multiple perspectives in any given situation.
- Capacity to rely on others and be reliable.
- Appreciating and understanding the values of both one's own and other cultures; and lastly,
- Utilising these skilled behaviours to achieve socially approved goals and to maintain healthy relationships of varying degrees of intimacy.

A review of this list shows high compatibility with Maslow's definition of self-actualising people, and a strong inclination towards internal as opposed to external locus of control. They concern life politics that are not so much "of life chances, but of lifestyle" (Giddens, 1996, p. 14). The term "life chances" intonates passive resignation to fate; "lifestyle" connotes proactive control of destiny. Thus, in a disability mindset, the self is not simply the traditional perception of disability as a physical, sensory or intellectual "abnormality." The self is reflexively determined (Giddens, 1996). Otherwise, such a person may be an inhabitant of a glass sphere and have the psychic mettle of veal.

Conclusion

Social emotional competence is vital to ensuring that individuals maximise their social, psychological, vocational and academic potential. Conceptualising stigma, as the social model effectively does, is only half the journey towards people with a disability "freeing" themselves from disabling experiences. It is a critical part nonetheless. Stigmatising social structures and practices need to be understood. There is no disputing this. But disability is not purely the result of social structures alone. Ableism is not totalitarian. Identity is not fixed. Emancipatory disability politics by-passing the perils of victimisation views the self as a social agent who is able to reflexively challenge stigmatisation, to turn adversity into a rewarding flow of experiences. It is not what happens to you but the way you view it.

Can the fat woman call herself disabled? If she sees herself as a victim and behaves like one she has every right to call herself disabled. She will be a social victim confined to a glass sphere whose barrier is externally and internally hardened. But if she reflexively challenges the externally imposed stigmas that come with societal pressures, if her self worth is internally validated through proactive lifestyle pursuits, then there is a likelihood that she is a self-actualising individual. Her glass sphere will have melted into a latex body wrap that enables her to touch and be touched by others (Jacobs, 2003). Being fat in a fat-hating culture is disabling for two reasons. The first is the external impositions and the second is the internal processes. Negative thought processes can exaggerate the externally imposed stigmas beyond their actual worth. This can create an ontologically intolerable experience that has little or nothing to do with physical, sensory or intellectual "abnormalities." It is not the actual condition that is causing the disability, but rather the disabling thoughts. In effect, many people with a disability have an additional disability largely unseen–a social disability. It is common to see stigmas as a blueprint for ones own past, present and future. Yet, according to Maslow, one prominent characteristic of self actualising people is that they refuse to be handicapped by negative social perceptions of who they are as a person. With emotional intelligence they detraditionalize what it means to be fat, or disabled, in a personal and political domain.

The contemporary psychosocial approach to understanding disability goes beyond the social model. Without it, we will continue to show how people with a disability are a ghettoised social minority. We will never fully understand disabling socio-cognitive processes. We will never know the prescriptive courses of action on a personal level that we need to infiltrate into mainstream society, to maximise our psychosocial potential. The benefit of this emancipatory interpersonal politics is that it is applicable to all kinds of disabilities. Originally used to "free the minds" of "normals," socio-cognitive therapy puts people with a disability on an equal plane with others. The disablement does not lie totally in the construction of society. Lack of social and personal support is not exclusive to society's barriers. Disabling prejudice and discrimination is not just the result of a physical, sensory or intellectual "abnormality." Inclusion is mutually generated.

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