Disability, impairment or illness? The relevance of the social model of disability to the study of mental disorder

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Abstract   Sociologists appear to have abandoned the study of serious mental illness. This paper argues that the work of the disability theorists provides new directions for an analysis of the plight of people suffering from serious mental illness. Disability theory, revolving around a 'social approach to disability', redirects analysis from the individual to processes of social oppression, discrimination and exclusion. The application of the ideas of disability theorists to the study of mental ill health will orient research and theoretical development towards an analysis of the complexity and multiplicity of the social restrictions faced by people diagnosed as 'mentally ill', and the social disadvantage and oppression they face. A number of vigorous debates within the disability theory literature are examined. One debate addresses the political and theoretical implications of identifying the differences that exist between people with disabilities. A second debate examines the relative importance of including an analysis of impairment in the social approach to disability. Finally, the paper discusses the critique of medical sociology, linking illness with disability, which is advanced by some disability theorists. This debate is particularly concerned with the linking of illness with disability and the ideological and conceptual disadvantages of a focus on illness.

Introduction

As a result of major changes in mental health policy most people with a severe mental disorder now live in the community. The experience of severe

mental disorder is frequently associated with economic hardship, unemployment, a breakdown in social relationships and a lowered standard of living. Sociological theory and research has not provided either a much-needed analysis and critique of the major changes taking place in mental health policy or fostered any recent social policy directed towards improving the quality of life for people diagnosed as suffering from severe mental illness who live in the community.

There is a long tradition of sociological work in the area of mental health and illness (Busfield 1996, Pilgrim and Rogers 1993). The earliest sociological work addressed the influence of social and economic factors on the development and distribution of 'disorders of the mind' (see, for example, Hollingshead and Redlich 1958, Faris and Dunham 1939)[1]. During the 1960s and 1970s the social constructionists examined both psychiatric[2] and community understandings of mental illness, and their impact on those labelled as mentally ill (see Scheff 1966, Schur 1971, Strauss *et al*. 1964). Other sociologists, such as Prior (1993) and Scull (1979), have traced the changing modes of treatment of the mentally ill over the last century. More recently a number of sociologists (see, for example, Rose 1996, De Swaan 1990) drawing on Foucault, have studied changes in the ideology and practices of psychiatry in a postmodern society. The increasing psychiatric interest in the relationship between violence and mental disorder and the introduction of techniques of risk assessment and management have also been analysed (see Castel 1991 and McCallum 1997).

While recognising the value of much of this work, this paper argues that sociologists appear to have abandoned the study of serious mental illness[3]. Although labelling theorists and members of the anti-psychiatry movement asked many important questions, their responses were often crude and unsophisticated. The blanket condemnation of psychiatric intervention and the determination to portray all mental disorders as social constructs, led their work into disrepute. The more recent theoretical focus on the 'discursive practices' of psychiatry, although important, has less relevance for the study of serious psychiatric disorders (Pilgrim and Rogers 1994).

The focus in this paper on people with serious mental disorders is based on the assumption that for a small, but significant category of people, mental disorder is associated with severe restrictions on social, psychological and physical wellbeing. Although the severity of the symptoms associated with serious mental disorders may fluctuate, for many people they remain chronic. People suffering from severe mental disorders are likely to attract one of a number of medical diagnoses listed in traditional psychiatric classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). These diagnoses include major psychotic conditions such as schizophrenia and affective psychoses, involving mood disorders such as manic-depression and major depression. They may also include serious anxiety disorders including obsessive-compulsive disorders and phobias. These diagnostic categories, though problematic, do enable a

distinction between serious psychiatric disorders and other milder mental health problems[4].

Disability theory

This paper argues that sociologists should re-visit the study of serious mental disorder and suggests that a direction forward can be found in the writings of the disability theorists. Developments in disability theory have emerged largely from the work of a group of British writers and researchers (see, for example, Barton 1996)[5]. This work is often referred to as the 'social model of disability' (Drake 1999: 10) or the 'social barriers model of disability' (Finkelstein 1993: 36). However, as work in this area is constantly being developed and refined by writers from a range of different theoretical backgrounds, it is more appropriate to refer to the work as 'the social approach to disability' (Barnes *et al.* 1999: 27). There is an increasing diversity of views about how theorising in this area should proceed; nonetheless there are a number of defining characteristics of the approach.

Writers challenge conventional 'individualist and deficit views of disability' (Barton 1993: 235). A distinction is made between impairment and disability. As one of the best-known theorists Michael Oliver writes: '[disability is] the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of social activities' (1990: 11). Impairment, on the other hand, refers to some bodily defect, usually constituting 'a medically classified condition' (Barnes *et al.* 1999: 7). This location of the conceptualisation and analysis of disability within a social framework redirects analysis from the individual to processes of social oppression, discrimination and exclusion. The disadvantage experienced by disabled people is seen to be 'institutionalised throughout society' (Oliver 1996: 33).

The social approach to disability demands an identification and analysis of the social, political and economic conditions that restrict the life opportunities of those suffering from an impairment. Central to this work is a focus on the rights of people with disabilities and the consequences of the development of a collective identity for social action and social change. Thus, in addition to promoting new ways of conceptualising and analysing disability, the social approach to disability has an ideological component. A focus on political action gives 'disabled people a feeling of self-worth, as well as offering them a collective identity and a stronger political organization' (Butler and Bowlby 1997: 412).

Although disability theorists have rarely included psychiatric disability in their work[6], their ideas can be used to inject new vigour and direction into an analysis of the plight of people suffering from mental illness. The application of the social approach to disability to the study of mental ill health

orients research and theoretical development towards an analysis of the complexity and multiplicity of the social restrictions faced by people diagnosed as 'mentally ill', and the social disadvantage and oppression they face. It directs sociologists to identify the sites and the mechanisms of institutionalised oppression. This focus moves far beyond the work of symbolic interactionist theorists, such as Scheff (1966), whose concern with societal reaction was largely restricted to the use of diagnostic stereotypes by psychiatrists. Goffman's work on stigma (1961) is also narrowly focused on 'the defensive, anxiety-ridden and largely doomed manoeuvrings of stigmatized individuals, and of their acceptance of the negative label' (Barnes *et al.* 1999: 47).

The focus on institutionalised oppression would extend the sociology of mental health beyond the study of psychiatry and medical treatment to an examination and identification of the social barriers that deny or restrict access for people with a serious psychiatric disability to the rights of citizenship[7]. This focus would include the analysis of urban space (Imrie 1998), housing (Morris 1993), education (Roulstone 1993), recreation (Fullager and Owler 1998) and employment (Baron *et al.* 1998). The implications of ideologies of economic rationalism, consumerism and neoliberalism for the delivery of medical and welfare services for people with a psychiatric disability would be examined. The reality of systems of 'community care' for people with psychiatric disabilities in an era dominated by managerialism, privatisation, the introduction of the market ideology and the mixed economy of welfare would be assessed (Pilgrim *et al.* 1997). A focus on oppression, citizenship and rights within the sociology of mental health challenges sociologists to ground the relevance of their theoretical and empirical work in the lives of people suffering from serious psychiatric disorders.

The social approach to disability provides a framework from within which to analyse social policy of relevance to people with psychiatric disabilities. Writers in the disability area are concerned to draw out the implications of their analysis for the development of social policy and the growth of the disability movement (Barnes and Oliver 1995, Shakespeare 1993). Disability theorists' examination of the current policy focus on needs instead of rights (Sullivan and Munford 1998), the linkage of rights and responsibilities of citizens (Barton 1993), and the analysis of the gap between the rhetoric of inclusive citizenship and the reality of resource delivery (Davis 1998) remain highly relevant to an examination of the experience of living with a serious psychiatric disorder. The social approach to disability also calls for a reassessment of the role of legislation as a vehicle for social change (Barnes and Oliver 1995).

Existing mental health policy is based on the assumption that the major problems and 'medical symptoms' faced by people with serious psychiatric disabilities result from their illness. Broader social structural factors that affect an individual's experiences of illness, such as poverty, inequality,

discrimination and exclusion are not targeted[8]. People with mental disorders have been excluded from generic disability programmes in areas such as employment and training, housing and accommodation support, generic social support, recreation and disability services. The relevance of narrow mental health legislation which primarily regulates the delivery of medical services in hospitals, to the needs of people living in the community has not been challenged. The sociology of mental health has done little to clarify the nature of the social barriers faced by people with serious psychiatric disorders living in the community.

The social approach to disability is, however, still being developed and refined (Barton 1993, Oliver 1996, Shakespeare and Watson 1997). For instance, although Oliver's model is built on a materialist theoretical perspective, social approach theorists are increasingly drawing on a range of theoretical perspectives, including social constructionism and post-modernism. One of the major attractions of this body of work, however, is the use of theory to both understand 'why things are the way they are' and to establish 'a future agenda for social change' (Riddell 1996: 103). Whilst the model does not offer a comprehensive theoretical framework within which work in the sociology of mental health should proceed, the recent work of disability theorists identifies a range of highly pertinent questions of relevance to the study of mental disorder.

Writers drawing on the social approach to disability share a commitment to explaining the structural constraints that create disability. There is, however, much lively debate about how the approach should be developed and refined (Shakespeare and Watson 1997, Oliver 1996, Barton 1993, Butler and Bowlby 1997, Watson 1998). This paper argues that these debates highlight issues and dilemmas of major relevance to the study of psychiatric disability. Three areas of controversy with disability theory will be examined. First, the relative importance of incorporating an understanding of the differences that exist between disabled people is a source of tension between theorists. A second concern relates to the importance of theorising impairment, as well as a concern to examine the relationship between impairment, identity, disability and empowerment. Finally, disability theorists have questioned the applicability of work in the sociology of health and illness to the study of disability.

Significance of difference

A major debate within disability theory relates to the importance of acknowledging differences between people with disabilities. Some argue that the social approach to disability should focus on the common social oppression which people with disabilities face, and on their need to unite politically to fight this oppression (Oliver 1996). Others contend that the conceptualisation of disability as a monolithic experience ignores differences that exist

between people with disabilities based on class, gender, race and ethnicity, sexual orientation and age (Barton 1993, Crow 1996, Hearn 1991, Lloyd 1992).

Associated with this failure to acknowledge difference, it is claimed, is a disinterest in people's perceptions of living with impairment and disability. This lack of focus on disabled people's experiential knowledge detracts from the relevance of the social approach for many people with disabilities (French 1993, Morris 1992, Crow 1996). An analysis of people's experiences of impairment and disability, it is argued, will both enhance theoretical understandings of the nature and impact of social barriers for people with disabilities (Thomas 1997) while simultaneously providing insight into the differential impact of these restrictions on different categories of disabled people.

These concerns by some disability theorists, to link the importance of acknowledging personal differences with detailed analysis of individual experience, are highly relevant to the sociology of mental health. Ironically, whilst the work of interpretive sociologists in labelling theorists, and more recent Foucauldian theorists, has provided a critique of psychiatry and its impact on 'mental patients', this work has actually reinforced some of the worst aspects of medicalisation. The person with a mental illness is constructed as the 'other' (Peters 1996: 218). Labelling theorists, although highlighting the social process of stigmatisation and exclusion, portrays the 'deviant' as a victim (see Becker 1963, Lemert 1962). This 'oversocialised' view ignores the 'bodily identity, personhood, and transformative potentials' of the stigmatised individual (Peters 1996: 218). This kind of research ignores the diversity of experience existing between people suffering from mental disorders.

An exploration of how these experiences might differ depending on factors such as age, gender, ethnicity or even attributed psychiatric diagnoses has rarely been done[9]. The consequences of this failure to explore difference limits the ability of sociological research to analyse and explore the complexity, subtlety and diversity of disabling barriers faced by people suffering from mental disorders. Additionally, the tendency to conceptualise 'mental patients' as an undifferentiated group of victims restricts the potential of sociological research and theorising to both analyse and support the interests of the developing mental health consumer movement. As Barnes and Shardlow (1996: 131) point out, 'it is important to understand and to theorise personal responses of mental distress in order to make the link between such experiences and collective action'[10].

There are, however, some notable exceptions to these failures that suggest possibilities for future research. Two recent qualitative studies of the experiences of users of mental health services (Rogers *et al.* 1993, Wadsworth and Epstein 1998) address the importance of understanding the perceptions of individuals accessing mental health services. These studies explore the interface between medical services and the users of these services. While this focus is understandable, given the importance of medical treatment in the lives of people suffering from serious psychiatric disorders, the social

location of the individual and their perceptions of the significance of their mental health problems in terms their wider life experiences, is not, unfortunately, addressed.

Barham and Hayward (1991) explore the wider significance of a mental disorder in the lives of a small group of people diagnosed as suffering from a schizophrenic illness. A particularly significant aspect of this qualitative study is the researchers' inclusion of their participants as active collaborators in the research process. The research identifies both the participants' perceptions of the difficulties they face in negotiating their illness and its treatment, as well as their active attempts to maintain or create an identity as a person rather than as a mental patient. More research like this, that compares the experiences of different categories of people living in the community with serious mental disorders is essential.

Impairment and disability

Disability theorists are divided in their views about the importance of theorising impairment. For many disability theorists, the distinction between impairment and disability is fundamental. They argue that there are ideological reasons for not focusing on impairment (Oliver 1996). They are concerned that the acknowledgement of the pain of impairment will lead to a renewed focus on physical limitations (Shakespeare 1996). A return to the ascendancy of the medical model, with its focus on blaming the victim will lead to the dissipation of the disability political movement (Shakespeare and Watson 1997).

Conversely, those theorists advocating a focus on the differences between people with disabilities are concerned to ensure that the social approach to disability incorporates an analysis of impairment. They argue that to ignore impairments is to ignore the 'reality' of the lived experiences of people with disabilities (see, for example, Crow 1996, French 1993, Hughes and Paterson 1997, Shakespeare and Watson 1995). It is argued that the effect of pain, physical restrictions on movement, loss of function and exhaustion can be as frustrating and depressing as ridicule, abuse, stigma and discrimination (Butler and Bowlby 1997, Pinder 1995). As Williams argues, disability is 'at some level, undeniably to do with the pain or discomfort of bodies, and this is a dimension of the oppressive quality of chronic illness and disability for large numbers of people' (1996: 205–6).

Sociological work in the area of mental disorder has largely ignored issues of impairment[11]; the individual's experience of illness is disregarded. The anti-psychiatrists explicitly deny the possibility of 'illness' (Szatz 1961) and the post-structuralists portray mental illness as the product of discourse (Seymour 1998). The focus of the research of labelling theorists is on the nature of the social reaction, rather than on the perceptions of those labelled (see, for example, Lemert 1962, Sampson et al. 1962). Labelling theorists

who make a distinction between primary and secondary deviance disregard impairment and focus only on those aspects of a person's identity believed to be related to the social reaction to their condition. The major argument of these theorists is that the role of the mental patient is consolidated by the social reaction of friends, relations and medical professionals (Goffman 1968).

A focus on mental impairment appears to pose a greater challenge for sociologists than a focus on physical impairment. An acceptance of the mind/body dualism has allowed sociologists generally to take as unproblematic the existence of physical illness and impairment (without impeding the study of the contribution social structural factors make to the development of these conditions). The ontological status of madness has been viewed, however, as far more problematic. Although the portrayal of mental disorders as social constructions has provided a much-needed challenge to the essentialist view of the body portrayed in medical science, it has placed major limitations on sociological inquiry.

Sociologists working in the area of mental health have been loath to confront the possibility that a range of mental impairments exists which make the performance of certain activities difficult for people who suffer from these impairments. Traditionally, sociologists have avoided the dilemmas of confronting the implications that may flow from an acknowledgement that some people experience severe pain and discomfort as a result of disorganised thinking, racing thoughts, fixed paranoid delusions, inability to control thought processes or perceptions of external thought control. This makes their work increasingly irrelevant for many people experiencing serious mental distress. Barnes and Shardlow (1996: 130) provide a succinct summary of this failure when they argue that the sociology of mental health has not been able to develop 'an alternative model (equivalent to the social model of disability) which can provide the basis for both understanding the origin and nature of distress and providing enabling and empowering assistance to those experiencing such distress'.

Embodied impairment

Sociological work can gain from examining the writings of disability theorists attempting to grapple with the consequences of including impairment in their theorisation of disability. A number of disability theorists, concerned to incorporate the significance of impairments into the social approach to disability, have drawn on work from the sociology of the body to refine their analysis of the relationship between impairment and disability. These theorists argue that the social approach must see impairment as 'embodied', rather than as presenting a biologically reductionist depiction of the body where the body is seen as separate from society (Butler and Bowlby 1997: 418)[12]. One's experience of embodiment, it is argued, is the result of a

complex relationship between society and corporeality. As the body is both a corporeal and a social construction, so our experience of embodiment is both sensory and 'shaped by social relations and ideas' about normal bodily form (Butler and Bowlby 1997: 416). Similarly an individual's identity is partly a product of their experience of embodiment (1997: 416). The mind/body dualism has discouraged an exploration of how people make sense of their physicality and corporeality and how this in turn impacts on their identity. If we accept these arguments we are led to acknowledge that 'selves', identity and agency cannot be studied independently of bodies, whether impaired or otherwise.

Theorists in the sociology of the body have ignored the mind or brain. There has been no attempt to apply the concept of embodied impairment to intellectual and psychiatric disability. The concept of embodied impairment can, however, include mental impairments. We can speak of 'embodied irrationality'. The concept of embodiment dissolves the mind/body distinction. In so doing, it also eliminates the need to distinguish between physical and mental impairments. As Seymour points out: 'If sociology is the interpretative understanding of social action, then embodied human beings, human personality and consciousness embodied in human material, are engaged in that action' (1998: 9).

The concept of embodiment allows sociologists to see the body as both a 'biological phenomenon' and a 'social production' (Seymour 1998: 12). A focus on 'embodied irrationality' encourages the study of how people make sense of the bodily experiences of insanity without falling back on a biologically determinist view of 'madness'. With the increased scientific interest in the genetic basis of mental illness and the development of new antipsychotic medications the relevance of the social to an understanding of mental distress faces new challenges. The concept of embodied irrationality provides a focus for a sociological contribution to the understanding of the complex relationship between biological and social factors. This conceptualisation allows 'the possibility of interdisciplinary research between traditional enemies, the biological and the social sciences' (Seymour 1998: 13) rather than conceding this territory to the biological sciences.

An area of major concern for many people suffering from serious mental disorders is the assessment by psychiatrists that the person lacks 'insight' into his/her illness. Research into people's explanations of the significance, meaning, and status they attribute to what appear to be psychotic symptoms, such as hallucinations, is an example of an area where the concept of embodied irrationality could be pursued (Barrett 1996). It is also an area in which the relationship between sociocultural, psychological and neurological influences could be examined. Similarly research into 'disease outcomes' should not be the sole province of medical researchers. Sociologists must challenge concepts such as 'the natural history of schizophrenia', but must do so within a framework that allows for the incorporation of ideas about

'biological disorder', cultural meanings, professional ideologies and social structural constraints.

A number of disability writers argue that the concept of embodied impairment allows for a more sophisticated analysis of people's experience of disabling environments. These theorists have made explicit the relationship between impairment, disability and environment. Butler and Bowlby (1997), for example, examine the use of public space by people with visual impairments. By focusing on individuals' perceptions of their experiences in public spaces the researchers analyse the different way people with visual impairments confront and negotiate a range of social and physical barriers. They also emphasise, though, 'the reflexive relationship between bodily and social experience' (1997: 422). They illustrate how shared understandings and expectations about disability affected their respondents' 'embodied experience of being in public space and how their physical experiences interact with their views of themselves and their relationship to others' (1997: 422). Pinder (1995) looks at the experiences of people with chronic arthritis in managing paid work. She explores her respondents' attempts to accommodate their episodic and unpredictable arthritic symptoms with employment that demands regular hours of employment.

Research that analyses the negotiation of disabling environments by people with serious mental disorders must be undertaken. Research in Australia, for example, has shown that university students suffering from psychiatric disorders face major problems in completing their courses, partly due to impairment-related factors. In addition to stigmatising treatment by staff and fellow students, many encountered problems in completing assessment tasks within the stipulated time frames or in regularly attending classes because of their fluctuating symptoms (National Centre for Vocational Education Research, 1999). Avoidance of the issues of impairment means that researchers in the sociology of mental health rarely undertake sophisticated analyses of the relationship between impairment, disability and environment, or identify the policy implications that flow from such analyses.

The work of disability researchers highlights first, the limitations of conceptualising social barriers in crudely simplistic and determinist terms and secondly, the importance of acknowledging impairment, agency and difference. People's management of their lives will vary depending partly on the nature of their impairment, their self perceptions, their immediate social and physical context and the broader social, cultural, economic and political environment (Butler and Bowlby 1997: 421). Social policy developments, it is argued, must be built on this recognition.

These disability theorists seek to combine a focus on structure, agency and meaning. They argue that the focus on individuals' understandings of how impairment and disability is experienced (Hughes and Patterson 1997) restores a focus on agency and identity. They are particularly interested in how positive self-identity can be established and how the experience of impairment can lead to empowerment rather than disempowerment

(Shakespeare 1996, Barnes and Shardlow 1996). The application of these ideas to an analysis of, for example, 'psychiatric system survivor' movements (Beresford 2000) presents a particular challenge for the sociology of mental health.

The contention that the study of disability should include both the analysis of disabling environments and the experience of embodied impairment (which cannot be separated) has major relevance for the study of psychiatric disability, which has generally failed to link personal experience to structural issues. These ideas provide a framework within which to study the impact of disabling barriers on people living with embodied irrationality.

Recent work by Parr, informed by a social approach to disability perspective, examines some of the problems people with mental disorders face in accessing public space and 'negotiating a "mentally ill" identity within the city' (1997: 441). By privileging 'the voice of the individual' Parr is able to detail individuals' reflections on how they negotiate survival in social spaces where a range of social barriers restrict their activities (1997: 436)[13]. They face marginalisation, exclusion and stigmatisation in their negotiation of public areas of the city (1997: 440). They seek out what Parr coins 'insane space' places: 'a bedroom, a park, a café, a pavement – momentary fleeting "insane spaces" where people can simply be themselves' (1997: 442). Parr's data suggest that his respondents' identities were influenced both by their interpretation of their mental attributes and the 'common sociocultural codings and understandings of how the self should be presented in everyday life' (1997: 451). An interesting part of Parr's data is the way his respondents identify those aspects of their behaviour that they see as causing concern in the community. They speak, for example, of feeling 'high', losing inhibition or having thinking that is 'a bit warped' (1997: 441)[14].

Medical sociology and the study of disability

Another set of issues raised by disability theory relates to the contribution medical sociology can make to the study of disability. Most disability theorists accept that there are some similarities between impairment and chronic illness and acknowledge that disabled people may require medical assistance from time to time (Barton 1993, Oliver 1996). All impairment should not, though, be studied from 'an illness perspective' (Barnes and Mercer 1996: 5). They are concerned that a focus on illness will restrict the ability of the social approach to disability to move from an individualistic to a social structural analysis of disability (Barton 1993). Oliver (1996), for example, contends that a focus on illness can lead to the posing of a causal relationship between chronic illness and disadvantage.

Many disability theorists are critical of the contribution medical sociologists can make to the study of chronic illness and disability. They argue that although research which examines the way people make sense of

living with illness or impairment is important, it highlights the negative aspects of illness and neglects the structural context within which meanings are shaped (Williams 1996: 202). This reinforces the 'victim' image of the person with a disability and a negative sense of self and identity (Barnes and Mercer 1996: 5). The social approach to disability, in contrast, focuses on empowerment and the development of an active disability rights movement committed to major social change (Oliver 1996).

Some disability theorists argue, however, that work in the sociology of health and illness can help address the failure of disability theorists generally to acknowledge the bodily discomfort and pain experienced by some people with disabilities. They point out that interpretative studies of chronic illness provide an alternative understanding to the experience of living with a chronic illness to that of professionals (Williams 1996: 203). Williams cites the work of Zola as an example of how 'a phenomenological and interactionist analysis of disability' could be located within 'a collectivist framework'[15].

Many disability theorists also argue that the social approach should be principally concerned with critiquing medical intervention only in those areas of a person's life that are unrelated to impairment or illness. They see much of the work within medical sociology, which is concerned with the interaction between medical personnel and their patients, as irrelevant to the study of disability. They are more concerned to critique medical and para-medical professionals' decision-making in areas of disabled people's lives including termination of pregnancies, sterilisation, access to employment, housing, welfare benefits and schooling (Oliver 1996: 36).

Not all disability theorists, however, endorse these views. While accepting the general thrust of these propositions a number of concerns have been raised. It is argued that the essentialist conceptualisation of the body within the social approach limits any challenge to medical dominance. As Hughes and Patterson point out, although the social approach critiques the medical model, it 'concedes the body to medicine and understands impairment in terms of medical discourse' (1997: 326). While the social disability theorists have avoided the mistake made by the anti-psychiatrists in their assertions that psychiatric impairments were total social constructions, they appear to have acceded too much to medicine. By so doing, they ignore the possibility of exploring the complex relationship existing between embodied impairment and disability. They also retreat from a critical analysis of all aspects of medical involvement in the lives of people with disabilities. Bury extends these arguments further with his claim that 'a full picture of disablement in contemporary populations inevitably exposes its health and illness dimensions' (Bury 1996: 22). The recognition of a link between illness, impairment and disability would include an acknowledgement that some people with disabilities will and do seek medical treatment. The distinction between impairment and disability, it is argued, leads theorists to ignore the 'legitimate' medical work related to the treatment of disease and illness for

people with a disability. The social approach to disability must acknowledge the legitimacy of medical activities while, at the same time, critiquing these activities where appropriate if it is to identify the full range of social barriers people with disabilities face.

The dilemmas raised in the above debate have direct relevance for the study of mental health. I have already discussed the importance of the concept of impairment to the sociology of mental health and the need to give prominence to the accounts given by people with mental disorders (Barnes and Shardlow 1996) of living with impairment and disability. The preceding discussion both cautions against research approaches that result in the reinforcement of a 'victim' identity for the person with the disability, and encourages research approaches that locate the individual's narratives within a broader structural context. These debates also suggest the need for sociologists to revisit their critiques of the medicalisation of mental disorders. The work of disability theorists suggests that such a sociological analysis will need to take a number of directions. The first of these would involve a re-examination of the operation of medical social control in the post-deinstitutionalisation era.

In the aftermath of the rather unsubtle social control theories of psychiatry developed in earlier decades (see, for example, Scull 1979), the analysis of 'the destructive and oppressive features of modern psychiatry' has been abandoned (Pilgrim and Rogers 1994: 525). Most recent work is being done by post-structuralists who analyse the increasing dispersal of discursive psychiatric and psychological practices of control among the 'worried well' (Rose 1990). While acknowledging the importance of this work, Pilgrim and Rogers (1994) are concerned that the pendulum has swung too far. They point out that the dominant response by institutional psychiatry to people with serious mental disorders still utilises preventative detention and a range of 'hospital-centred biological treatments' (1994: 531). The dominant mode of treatment for most people suffering from serious mental disorders is the prescription of psychotropic medication. This medication frequently has major side-effects that can severely restrict the ability of the user to engage in a range of social activities, including paid employment. The fact that medication is often enforced by the use of compulsory community treatment orders further complicates the effects of this treatment regime on the lives of those involved. The impact of the increasing use of mandatory community-based treatment in England, America and Australia, on the lives of people with serious mental disorders needs careful appraisal (Mulvany 1994).

A second direction in the analysis of medicalisation would be the examination of the influence of medical ideology on the formulation of mental health policy and its implementation. The disability experiences of people with a mental disorder are closely related to the conceptualisation of their 'problems' as essentially medical. Even in the post-deinstitutionalisation era, mental health policies still emanate predominantly from health departments,

and focus primarily on the way clinical services should be provided (Peck and Parker 1998, Australian Health Ministers 1992). The impact of a policy focus, located within a medical framework, on the lives of people living with a chronic illness in the community must be assessed. There is, of course, an increasing acknowledgement in policy documents, of the relevance of social factors in the lives of people living with major mental disorders and the necessity to develop links between health services and generic social support and welfare services. The critique emanating from the work of the social approach disability theorists suggests, however, that issues of control, discrimination, dependency creation and exclusion will not dissipate with the development of such partnerships. Detailed analysis of the social barriers and constraints faced by people with serious mental disorders in their negotiation of these government sectors must be undertaken.

Finally, the work of the disability theorists suggests that a balance must be reached between acknowledging the ideological and conceptual disadvantages associated with a focus on illness, while recognising individuals' experiences with and concerns about impairment. Debates within disability theory have identified tensions and dilemmas associated with this recognition. One of these relates to the status to be given to the demands of the emerging health consumer groups for the improved delivery of medical services (see Barnes and Shardlow 1996). The concerns of consumers of psychiatric services include lack of access to medical services and acute hospital beds for people with serious psychiatric disorders. Consumers are particularly keen to identify ways of improving the delivery of health services to reduce stigmatisation, dependency and disempowerment (National Mental Health Strategy Evaluation Steering Committee 1997). Should these concerns be taken seriously or should they be seen as reflecting an uncritical acceptance of medical discourse regarding illness and diagnosis (Parr 1997, Chadwick 1996)? There has been little sociological analysis of the problems people with psychiatric disabilities may face both in accessing medical treatment and in the delivery of medical treatment within the community. Clearly for some people medicalisation provides meaning, understanding and legitimisation of their experiences of impairment (Broom and Woodward 1996). Sociologists should also, then, reassess medicalisation critiques in terms of the meaning of both disability and impairment in the lives of mental health consumers.

Conclusion

It is not suggested that the work of disability theorists holds all the answers. It is, however, an area in which interesting and challenging ideas are being developed. The social approach developed by disability theorists offers a way forward for analysis of the situation of people suffering from major psychiatric disabilities and provides a coherent analytical framework within

which to examine the social creation of psychiatric disability. A number of issues being debated by disability theorists have particular significance for the sociology of mental disorder and psychiatry. A major challenge facing the sociology of mental health is how to deal with the concept of mental impairment and how to link this with the study of the social production of disability.

A related challenge is to sharpen the analysis of the medicalisation of mental disorder, while at the same time recognising the need to broaden the focus of sociological concern well beyond issues of medicalisation. An examination is required of the myriad of ways in which people with mental disorders are disabled in the post-deinstitutionalisation era, whilst still acknowledging serious illness and impairment. Disability theorists have unashamedly become involved in social change, policy critique and policy development. If medical sociology is to have significance in the new millennium, medical sociologists must embrace with renewed vigour the practical and policy implications of their theorising for those they study. Coincidentally, such an embrace may contribute to the quality of life of the psychiatrically disabled whose lives remain untouched by loftier theories.

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Notes

1 Sociological work in this area has continued (see, for example, Busfield 1996, Vega and Rumbaut 1991 and Warner 1985).
2 See Barrett 1996 for a fascinating recent analysis of the social construction of schizophrenia in a state psychiatric hospital in Australia.
3 See Cook and Wright 1995 for possible explanations for this lack of interest.
4 Some writers would prefer to make distinctions of the basis of the severity of the problems associated with mental illness, regardless of the psychiatric diagnosis. See, for example, the distinction made by the Australian Psychiatric Disability Coalition between 'serious mental illness' and 'serious mental health care problems' (National Community Advisory Group on Mental Health, 1994: 10).
5 There is also a vibrant disability studies literature developing in America (see, for example, Davis 1997).
6 A number of writers begin their discussions with a reference to impairments of the mind and body (see Butler and Bowlby 1997: 412), but most go on to discuss physical disability only. Others ignore mental disabilities altogether (e.g. Shakespeare and Watson 1997).
7 Some work in this area has commenced. See Barham and Hayward 1991 who examine the transition from 'patient' to 'person' and Goodwin 1997 who looks at citizenship rights in the context of mental health service usage.

8   The Australian National Mental Health Strategy, for example, is squarely located in the Mental Health Branch of the Commonwealth Department of Health and Family Services. Part of the Strategy focuses on linking needy individuals into support services, rather than addressing structural disadvantage through the development of policies that straddle and link government departments concerned with housing, education, employment and training.

9   Some important exceptions are research on the link between sexism (Busfield 1996, Miles 1988) and racism (Fernando 1988, Renshaw 1988) and the experience of psychiatric disability.

10   There has been little interest by sociologists in the study of the mental health user movement. For two exceptions see Barnes and Shardlow 1996 and Rogers and Pilgrim 1991.

11   There has, of course, been a small but long research tradition in the area of what Busfield (1989) calls 'the social causation' strand. Researchers, although often highlighting problems associated with the use of secondary data, acknowledge the existence of 'illness' while focusing on identifying the contribution social factors make to the patterns and occurrence of particular categories of mental illness.

12   Comparisons are made with the feminist movement. Its critique of the dualistic notion of sex and gender is compared to the distinction made between impairment and disability (Hughes and Paterson 1997: 333).

13   The ultimate example of the difficulties they may have in accessing public space is found in mental health legislation that allows people to be removed from both public and private places and confined involuntarily in a mental institution.

14   See Davies and Jenkins (1997) for a study of the construction of self-identity in young people with learning difficulties. The research highlights the complex inter-relationship between identity, discourse and bodily experiences.

15   See Thomas' 1997 study of the mothering experiences of women with disabilities and her identification of the 'attitudinal, ideological and material' social barriers faced by the women.

References

Australian Health Ministers (1992) *National Mental Health Policy*. Canberra: Australian Government Publishing Service.

Barham, P. and Hayward, R. (1991) *Relocating Madness: from the Mental Patient to the Person*. London: Free Association Books.

Barnes, C. and Oliver, M. (1995) Disability rights: rhetoric and reality in the UK, *Disability and Society*, 10, 1, 111–16.

Barnes, C. and Mercer, G. (eds) (1996) *Exploring the Divide: Illness and Disability*. Leeds: The Disability Press.

Barnes, C., Mercer, G. and Shakespeare, T. (1999) *Exploring Disability: a Sociological Introduction*. Oxford: Polity Press.

Barnes, M. and Shardlow, P. (1996) Identity crisis: mental health user groups and the 'problem of identity'. In Barnes, C. and Mercer, G. (eds) *Exploring the Divide: Illness and Disability*. Leeds: The Disability Press.

Baron, S., Riddell, S. and Wilkinson, H. (1998) The best burgers? The person with learning difficulties as worker. In Shakespeare, T. (ed) *The Disability Reader: Social Science Perspectives*. London: Cassell.

Barrett, R. (1996) *The Psychiatric Team and the Social Definition of Schizophrenia: an Anthropological Study of Person and Illness*. New York: Cambridge.

Barton, L. (1993) The struggle for citizenship: the case of disabled people, *Disability, Handicap and Society*, 8, 3, 235–48.

Barton, L. (ed) (1996) *Disability and Society: Emerging Issues and Insights*. Essex: Addison Wesley Longman.

Becker, H. (1963) *Outsiders: Studies in the Sociology of Deviance*. New York: Free Press.

Beresford, P. (2000) What have madness and psychiatric system survivors got to do with disability and disability studies? *Disability and Society*, 15, 1, 167–72.

Broom, D. and Woodward, R. (1996) Medicalisation reconsidered: toward a collaborative approach to care, *Sociology of Health and Illness*, 18, 3, 357–78.

Bury, M. (1996) Defining and researching disability: challenges and responses. In Barnes, C. and Mercer, G. (eds) *Exploring the Divide: Illness and Disability*. Leeds: The Disability Press.

Busfield, J. (1989) Sexism and psychiatry, *Sociology*, 23, 3, 343–64.

Busfield, J. (1996) *Men, Women and Madness*. London: Macmillan.

Butler, R. and Bowlby, S. (1997) Bodies and spaces: an exploration of disabled people's experiences of public space, *Environment and Planning D: Society and Space*, 15, 4, 379–504.

Castel, R. (1991) From dangerousness to risk. In Burchell, G., Gordon, C. and Miller, P. (eds) *The Foucault Effect: Studies in Governmentality*. London: Harvester Wheatsheaf.

Chadwick, A. (1996) Knowledge, power and the Disability Discrimination Bill, *Disability and Society*, 11, 1, 25–40.

Cook, J. and Wright, E. (1995) Medical sociology and the study of severe mental illness: reflections on past accomplishments and directions for future research, *Journal of Health and Social Behaviour*, (Extra Issue), 95–114.

Crow, L. (1996) Including all of our lives: renewing the social model of disability. In Morris, J. (ed) *Encounters with Strangers: Feminism and Disability*. London: The Women's Press.

Davies, C. and Jenkins, R. (1997) 'She has different fits to me': how people with learning difficulties see themselves, *Disability and Society*, 12, 1, 95–109.

Davis, L. (ed) (1997) *The Disability Studies Reader*. New York: Routledge.

Davis, L. (1998) Rights replacing needs: a new resolution of the distributive dilemma for people with disabilities in Australia? In Hauritz, M., Sampford, C. and Blencowe, S. (eds) *Justice for People with Disabilities: Legal and Institutional Issues*. Sydney: The Federation Press.

De Swaan, A. (1990) *The Management of Normality: Critical Essays in Health and Welfare*. London: HMSO.

Drake, R. (1999) *Understanding Disability Policies*. Basingstoke: Macmillan.

Faris, R. and Dunham, H. (1939) *Mental Illness in Urban Areas*. Chicago: University of Chicago Press.

Fernando, S. (1988) *Race and Culture in Psychiatry*. London: Croom Helm.

Finkelstein, V. (1993) Disability: a social challenge or an administrative responsibility? In Swain, J., Finkelstein, V., French, S. and Oliver, M. (eds) *Disabling Barriers – Enabling Environments*. London: Sage.

French, S. (1993) Disability, impairment or something in between? In Swain, J., Finkelstein, V., French, S. and Oliver, M. (eds) *Disabling Barriers – Enabling Environments*. London: Sage.

Fullagar, S. and Owler, K. (1998) Narratives of leisure: recreating the self, *Disability and Society*, 13, 3, 441–50.

Goffman, E. (1961) *Stigma*. Harmondsworth: Penguin.

Goffman, E. (1968) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Harmondsworth: Penguin.

Goodwin, S. (1997) *Comparative Mental Health Policy*. London: Sage.

Hearn, K. (1991) Disabled lesbians and gays are here to stay. In Kaufman, T. and Lincoln, P. (eds) *High Risk Lives: Lesbian and Gay Politics after the Clause*. Bridport: Prism Press.

Hollingshead, A. and Redlich, F. (1958) *Social Class and Mental Illness*. New York: Wiley.

Hughes, B. and Patterson, K. (1997) The social model of disability and the disappearing body: towards a sociology of impairment, *Disability and Society*, 12, 3, 325–40.

Imrie, R. (1998) Oppression, disability and access in the built environment. In Shakespeare, T. (ed) *The Disability Reader: Social Science Perspectives*. London: Cassell.

Lemert, E. (1962) Paranoia and the dynamics of exclusion, *Sociometry*, 25, 1, 2–20.

Lloyd, M. (1992) Does she boil eggs? Towards a feminist model of disability, *Disability, Handicap and Society*, 7, 3, 207–21.

McCallum, D. (1997) Mental health, criminality and the human sciences. In Petersen, A. and Bunton, R. (eds) *Foucault, Health and Medicine*. London; Routledge.

Miles, A. (1988) *Women and Mental Illness: the Social Context of Female Neurosis*. Brighton: Wheatsheaf.

Morris, J. (1992) Personal and political: a feminist perspective on researching physical disability, *Disability, Handicap and Society*, 7, 2, 157–66.

Morris, J. (1993) Housing, independent living and physically disabled people. In Swain, J., Finkelstein, V., French, S. and Oliver, M. (eds) *Disabling Barriers – Enabling Environments*. London: Sage.

Mulvany, J. (1994) Medicalization, marginalization and control. In Waddell, C. and Petersen, A. (eds) *Just Health: Inequality in Illness, Care and Prevention*. Melbourne: Churchill Livingstone.

National Centre for Vocational Education Research (1999) *The Learning Support Needs of Students with Psychiatric Disabilities Studying in Australian Post-secondary Institutions*. Melbourne.

National Mental Health Strategy Evaluation Steering Committee (1997) *Evaluation of the National Mental Health Strategy: Final Report*. Canberra: Mental Health Branch, Commonwealth Department of Health and Family Services.

Oliver, M. (1990) *The Politics of Disablement*. London: Macmillan.

Oliver, M. (1996) *Understanding Disability: from Theory to Practice*. London: Macmillan.

Parr, H. (1997) Mental health, public space, and the city: questions of individual and collective access, *Environment and Planning D: Society and Space*, 15, 435–54.

Peck, E. and Parker, E. (1998) Mental health in the NHS: policy and practice 1979–98, *Journal of Mental Health*, 7, 3, 241.

Peters, S. (1996) The politics of disability identity. In Barton, L. (ed) *Disability and Society: Emerging Issues and Insights*. Essex: Addison Wesley Longman.

Pilgrim, D. and Rogers, A. (1993) *A Sociology of Mental Health and Illness*. Buckingham: Open University Press.

Pilgrim, D. and Rogers, A. (1994) Something old, something new...: sociology and the organisation of psychiatry, *Sociology*, 28, 2, 521–38.

Pilgrim, D., Todhunter, C. and Pearson, M. (1997) Accounting for disability: customer feedback or citizen complaints? *Disability and Society*, 12, 1, 3–15.

Pinder, R. (1995) Bringing back the body without the blame? The experience of ill and disabled people at work, *Sociology of Health and Illness*, 17, 5, 605–31.

Prior, L. (1993) *The Social Organization of Mental Illness*. London: Sage.

Renshaw, J. (1988) *Mental Health Care to Ethnic Minority Groups*. London: Good Practices in Mental Health.

Riddell, S. (1996) Theorising special educational needs in a changing political climate. In Barton, L. (ed) *Disability and Society: Emerging Issues and Insights*. Essex: Addison Wesley Longman.

Rogers, A. and Pilgrim, D. (1991) 'Pulling down churches': accounting for the British Mental Health Users Movement, *Sociology of Health and Illness*, 13, 2, 129–48.

Rogers, A., Pilgrim, D. and Lacey, R. (1993) *Experiencing Psychiatry, Users' Views of Services*. London: Macmillan.

Rose, N. (1990) *Governing the Soul: the Shaping of the Private Self*. London: Routledge.

Rose, N. (1996) Psychiatry as a political science: advanced liberalism and the administration of risk, *History of the Human Sciences*, 9, 2, 1–23.

Roulstone, A. (1993) Access to new technology in the employment of disabled people. In Swain, J., Finkelstein, V., French, S. and Oliver, M. (eds) *Disabling Barriers – Enabling Environments*. London: Sage.

Sampson, H., Messinger, S. and Towne, R. (1962) Family processes and becoming a mental patient, *American Journal of Sociology*, 68, 88–96.

Scheff, T.J. (1966) *Being Mentally Ill*. London: Weidenfeld and Nicholson.

Schur, E. (1971) *Labelling Deviant Behaviour*. New York: Harper and Row.

Scull, A. (1979) *Museums of Madness: the Social Organization of Insanity in 19th Century England*. London: Allen Lane.

Seymour, W. (1998) *Remaking the Body: Rehabilitation and Change*. Sydney: Allen and Unwin.

Shakespeare, T. (1993) Disabled people's self-organisation: a new social movement? *Disability, Handicap and Society*, 8, 3, 249–64.

Shakespeare, T. (1996) Disability, identity and difference. In Barnes, C. and Mercer, G. (eds) *Exploring the Divide: Illness and Disability*. Leeds: The Disability Press.

Shakespeare, T. and Watson, N. (1997) Defending the social model, *Disability and Society*, 12, 2, 293–300.

Strauss, A., Schatzman, L., Bucher, R., Ehrlich, D. and Sabahin, M. (1964) *Psychiatric Ideologies and Institutions*. Glencoe, IL: Free Press.

Sullivan, M. and Mumford, R. (1998) The articulation of theory and practice: critique and resistance in Aotearoa New Zealand, *Disability and Society*, 13, 2, 183–98.

Szasz, T.S. (1961) *The Myth of Mental Illness*. New York: Hoeber-Harper.

Thomas, C. (1997) The baby and the bath water: disabled women and motherhood in social context, *Sociology of Health and Illness*, 19, 5, 622–43.

Vega, W. and Rumbaut, R. (1991) Ethnic minorities and mental health, *Annual Review of Sociology*, 17, 351–83.

Wadsworth, Y. and Epstein, M. (1998) Building in dialogue between consumers and staff in acute mental health services, *Systemic Practice and Action Research*, 11, 4, 353–79.

Warner, R. (1985) *Recovery From Schizophrenia*. London: Routledge and Kegan Paul.

Watson, N. (1998) Enabling identity: disability, self and citizenship. In Shakespeare, T. (ed) *The Disability Reader: Social Science Perspectives*. London: Cassell.

Williams, G. (1996) Representing disability: some questions of phenomenology and politics. In Barnes, C. and Mercer, G. (eds) *Exploring the Divide: Illness and Disability*. Leeds: The Disability Press.