

**Sample of Scholarly Writing**

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*This sample of writing is an excerpt from a research proposal titled, “You Want to be Yourself and the World Asks You to be Your Disability: Exploring the Identities of College Students with Disabilities.”*

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### Introduction

People with disabilities comprise the largest minority group in the United States, with approximately 56.7 million Americans, or 20 percent of the population, having at least one disability (Brault, 2012; Smart, 2008). Yet, people with disabilities are vastly underrepresented in higher education, as they are far less likely than their temporarily able-bodied<sup>1</sup> peers to successfully transition from high school to college, be retained, earn a degree, and gain employment (Horn & Berkold, 1999; National Council on Disability, 2000; Wagner & Backorby, 1996; Yelin & Katz, 1994). However, aside from these statistics, people with disabilities are increasingly enrolling in postsecondary schools. In 1978, only 3 percent of college students reported having a disability. By 1996, the number of students with disabilities had doubled to 6 percent and by 2006 it had risen to 9 percent (National Center for Education Statistics, 1999; Haller, 2006). Unfortunately, people with disabilities' increasing presence at institutions of higher education has not resulted in additional scholarship to better inform faculty and staff about students with disabilities and to improve educators' practice. According to Junco and Salter (2004):

Students with disabilities could be considered a “forgotten minority” of student affairs practice in higher education (Henderson, 1999). Students with disabilities encounter stereotypes and prejudices that are similar to those faced by individuals from other underrepresented groups (Katz, Huss, & Bailey, 1998; Livneh, 1988; Pounds, 1987), yet the research on the development...of students with disabilities is quite scarce. (pp. 263-264)

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<sup>1</sup> Temporarily able-bodied is a term used to reflect that anyone can become disabled at any time, and many people will face disability at some point in their lives.

In addition to the lack of research involving students with disabilities, the existing research, particularly in the area of identity and identity development, focuses almost entirely on disability rather than adopting a holistic perspective.

Disability is often referred to as a “master status” identity, meaning that it takes precedence over all other aspects of identity. According to Jaeger & Bowman (2005):

Regardless of the time period or society, disability has tended to function as a “master status,” a classification that has more social import than anything else in defining an individual (Albrecht & Verbugge, 2000, p. 301). The classification of disability “floods all statuses and identities” of a person, so that “a woman who uses a wheelchair because of multiple sclerosis becomes a disabled mother, handicapped driver, disabled worker, and wheelchair dancer” (Charmaz, 2000, p. 284). The fact that disability is a master status offers some explanation as to why persons with disabilities remain outsiders to other social minority groups. A woman with a disability is mainly perceived by others in terms of her disability, not her gender. Similarly, others usually perceive a male Latino business executive with a disability as being disabled first, and everything else is secondary. (p. 12)

Existing research reflects this in the sense that most work involving identity and people with disabilities is focused on *disability* identity rather than the *identities* of people with disabilities.

For example, numerous models and theories exist to explain disability identity (e.g., Gibson’s (2006) Model of Disability Identity Development, Gill’s (1997) Four Types of Integration in Disability Development, Mackelprang and Salsgiver’s (1999) Life Stage Development Concept of Disability, Segall’s (1976) theory of “the sick role,” and Rolland’s (1988) categories of disability identity). Although many of these models and theories have

developed out of disability studies and related fields, they still examine disability rather than an individual's holistic identity, of which disability is a part, but not a master identity.

Furthermore, research on the theories and models described above with college students is virtually non-existent. However, studies that have focused on other aspects of students with disabilities' experiences (e.g., barriers to receiving accommodations, improving academic success and social engagement) have still found issues related to identity development. For instance, Marshak, Van Wiren, Raeke Ferrell, Swiss, and Dugan (2010) identified several "identity issues" experienced by students with disabilities, including: desire for self-sufficiency, desire to shed stigmatized identity from high school, and desire not to integrate disability into their college identity. These findings seemingly contrast the studies that assume disability is the "master status" identity for students with disabilities and suggest that college students with disabilities view themselves in a more holistic way and want others to as well.

### **Disability, Visibility, and the Experience of the "Master Status" Ideology**

The perception of disability as a master status identity may be influenced by whether a person can be visibly identified by others as disabled. Disabilities can be divided into two broad categories: invisible and visible. Invisible disabilities are disabilities that are not apparent or recognizable to others. Conversely, visible disabilities are disabilities that can be observed or perceived. Disabilities may be visible to others based on their physical characteristics (e.g., an amputated limb), or visible due to the aids a person uses (e.g., a wheelchair, cane, or hearing aids), or visible due to someone's behavior or communication style (e.g., having a severe speech impediment or communicating in American Sign Language). Some disabilities are intermittently visible or invisible—for example, a chronic illness may be invisible part of the time but may become visible if noticeable symptoms manifest. Other disabilities may be initially invisible but

may become visible based on their treatment—for example, a congenital heart defect is invisible in nature but a scar from open-heart surgery can make it observable to others.

People with invisible disabilities face the choice of “coming out” as disabled or not, whereas people with visible disabilities are ascribed the label of “disabled” whether they want it or not. In addition to exploring the holistic identities of college students who happen to have disabilities, this study is interested in better understanding how college students with disabilities respond to the perception of disability as a master status identity. Given this, this study will focus on visible disabilities because it is more likely people with visible disabilities will experience the perception from others that their disability is their defining identity.

### **Purpose of Study**

Research suggests students with disabilities are underrepresented in higher education and have been called “the forgotten minority” (Junco & Salter, 2004) in student affairs practice. The research on collegiate students with disabilities is limited, particularly in regards to their holistic identity and multiple social identities. Most scholarship is focused on *disability* identity; meaning the researcher assumes (perhaps intentionally or unintentionally) disability is the most important aspect of students with disabilities’ identities. This perspective aligns with the master narrative that disability defines a person and overshadows all other aspects of identity. Current research, while not focused specifically on students with disabilities, has shown singular identities do not define students. Jones and McEwen’s (2000) Model of Multiple Dimensions of Identity demonstrates how significant identity dimensions intersect and process contextual influences to depict a core sense of self or personal identity – “no one dimension may be understood singularly; it can be understood only in relation to all other dimensions” (p. 410). Furthermore, given the call for student affairs to focus on “the whole student,” or holistic student

development (Reason & Broido, 2011), we need to challenge the idea that disability is what centrally defines students with disabilities. Thus, the purpose of this study is to provide the space for students with visible disabilities to share counter narratives that help educators better understand how they make meaning of, respond to, and/or resist the master status narrative of disability as the central facet of their social identity development.

### **Research Questions**

The research questions guiding this study are:

1. How do students with visible disabilities make sense of their identity from a holistic perspective? How do students with visible disabilities make sense of their multiple social identities?
2. How do students with visible disabilities perceive and make sense of others' reactions to their disability? How do these reactions impact their sense of self?
3. How do students with visible disabilities make meaning of, respond to, and/or resist the view of disability as the "master status" identity?

### **Theoretical Perspective**

This study is grounded in a critical theoretical perspective. According to Creswell (2007), "Critical theory perspectives are concerned with empowering human beings to transcend the constraints on them" (p. 27). These constraints refer to identities that, through social institutions, are marginalized and oppressed, such as race, gender, class, age, sexual orientation, religion, and ability. Given temporarily able-bodied people have historically viewed disability as a "master status" identity, using a critical theory perspective will allow students with disabilities to tell their own stories, serving as counter-narratives (Solórzano & Yosso, 2002) to the

dominant view of disability as a tragedy that dominates a person's identity and prevents them from enjoying a full, high quality life.

I will also use the sociopolitical model of disability, also referred to as the social model, to guide my research (Smart, 2008). This model of disability frames disability as a social construction that is created through the built environment (i.e., how the environment is constructed) and attitudinal barriers. The primary goal of this model is civil rights and liberation for people with disabilities. Using the sociopolitical model of disability complements a critical theoretical perspective, given the goal of social change and the desire to provide space to hear typically silenced voices. It also meets an additional need in the disability studies literature, since most research is based on the biomedical model, which views disability as an individual problem or defect (Smart, 2008). Thus, more research is needed using the sociopolitical model of disability.

## **Literature Review**

### **Defining Disability**

There is no universally accepted definition of disability. Historically, people used the term disability predominately to signify inability; using disability in other contexts (e.g., to define a group of people or an aspect of identity) is a relatively recent development (Wasserman, Asch, Blustein, & Putman, 2011). Two of the most frequently cited definitions of disability are from the Americans with Disabilities Act of 1990 (ADA) and the World Health Organization. One of the most significant pieces of disability civil rights legislation, the ADA defines a person with a disability as:

a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a

person who is perceived by others as having such an impairment. (U.S. Department of Justice, 2009)

According to the World Health Organization (2011), the International Classification of Functioning, Disability, and Health defines disability as:

an umbrella term for impairments, activity limitations and participation restrictions.

Disability is the interaction between individuals with a health condition (e.g., cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g., negative attitudes, inaccessible transportation and public buildings, and limited social supports. (para 1)

In addition to using definitions established by legislation or international organizations, another approach to defining disability is to examine it through various models of disability.

### **Models of Disability**

Models of disability are frameworks that dictate how people construct disability.

According to Rothman (2003), disability models can answer foundational questions about disability, such as: “What creates disabling conditions in people? How can responsibilities for people with disabling conditions be met? Who should be meeting them?” (p. 3). Thus, disability models assist people in defining disability as well as providing a cause-and-effect perspective that leads to guidelines for responsibility. Rothman (2003) divides disability models into two broad categories: individual and societal.

#### **Individual Models of Disability.**

##### ***The Moral Model.***

The moral model, which is one of the oldest models of disability, is based primarily on religious views that have shaped moral thought in Western civilization (Rothman, 2003). Prior



to the emergence of the biomedical model, which I discuss in more detail later, the moral model provided the dominant view of disability in society. While some people believe the moral model is outdated, Rothman (2003) notes the moral model continues to be relevant because it is based on “two dominant strands of thought, existing side by side and simultaneously, that have influenced much of our thinking today: disability as a punishment for wrongdoing or sin and disability as creating an obligation in others to care for people” (p. 5). While few people in the United States espouse the belief that disability is a punishment for being sinful or evil, the moral model continues to be reflected in stories and fairy tales, as “evil” or “villainous” characters often have disabilities (e.g., Captain Hook in *Peter Pan*, Scar in *Lion King*, and Dr. No in the James Bond film *Dr. No*). Furthermore, many people continue to ascribe to the moral model by perceiving people with disabilities as needing help and worthy of pity (Smart, 2008).

### ***The Functional Model.***

The functional model posits that disability is defined by function for a specific individual. Smart (2008) elaborates:

The Functional Model of disability theorizes that the functions of the individual influence the definition of disability. Individuals who enjoy physical activities would probably be more affected by a mobility impairment than those who do not care for such activities.

Also, individuals whose work does not require physical strength, movement, or stamina would be less affected by mobility disability. (p. 67)

For example, it might not be considered too great of an impairment in many employment settings if an individual lost their pinky finger – unless that individual is a concert pianist (Smart, 2008).

Thus, two people could have the same disability but a vastly different disability experience because, under the functional model, disability is very specific to the individual. Most work on

the functional model has involved the work capacity of people with disabilities, and so some disability scholars have referred to it as an economic model that is predominately concerned with how much a person with a disability is able to produce, and in return, consume (Smart, 2008).

***The Biomedical Model.***

The biomedical model of disability, also referred to as the medical model, is currently the dominant model of disability in American society. The biomedical model regards disability as an impairment, abnormality, or defect – something pathological within a person’s body or mind, which is the cause for a person’s disability (Marks, 2002; Smart, 2008). Thus, disability is viewed as “a functional loss, the inability to independently and effectively do the things that other people can do,” such as walk, see, hear, learn, problem-solve, communicate, and think clearly and rationally (Rothman, 2003, p. 8).

Under the medical model, a person’s disability creates disadvantages and the individual is expected to try to prevail in spite of these disadvantages. Just as society expects people to maintain their health and take care of themselves, society expects people with disabilities to treat, rehabilitate, overcome, or cure their disability (Crow, 1996). In other words, disability is a problem that is solely the responsibility of the individual, thereby abdicating society of any responsibility.

A central aspect of the biomedical model is the reification of a dichotomy between normal/abnormal, natural/unnatural, and acceptable/deviant. According to Rothman (2003), the medical model is grounded in a

way of thinking [that] is *norm based*: The assumption is there is a standard, or norm, for what human beings are, how they should look and act, and what they should be able to do. People who deviate [from] the norm are lacking in some way.” (p. 8)

Thus, people who ascribe to the medical model view people with disabilities as abnormal, broken, tragic, and not fully human.

### **Societal Models of Disability.**

#### ***Environmental Model of Disability.***

The environmental model posits that an individual's environment (physical, cultural, or social) can define, cause, or amplify a disability (Smart, 2008). In terms of physical barriers, it is relatively clear how the environment can create or exaggerate a disability – for example, if all entrances to buildings had stairs, a person who was a wheelchair user would be largely unable to participate in school, work, or social activities. However, the environmental model also includes cultural and social factors, which can be more difficult to understand. Smart (2008) uses the example of foot binding in Manchurian China to demonstrate how disability under the environmental model is “not only a biological construction; it is also the result of social and cultural definitions” (p. 66). Foot binding, a practice in which Manchurian women had their feet bound tightly when they were young to prevent further growth, typically resulted in misshapen feet and difficulty walking. According to the standards of modern Western culture, many people might view these women as deformed and disabled. However, to the Manchurian people, these women were not deformed, but exalted for their feminine beauty. Furthermore, they were not disabled but privileged because they could afford not to work and men viewed the difficulty they had walking as enticing. This practice demonstrates how the cultural and social environment can define disability.

#### ***The Sociopolitical Model.***

The sociopolitical (or social) model of disability contrasts the biomedical model, because it “locates disability within society: in the *built environment* and the *values* and *social practices*

which *discriminate* against people” (Marks, 2002, p. 52, italics in original). Crow (1996) defined disability under the social model as “the loss or limitation of opportunities resulting from direct and indirect discrimination” and stated that social change (or the removal of disabling barriers) was the solution to disadvantages rather than treating or curing disability (p. 2). The social model dictates that the problem is not the person, but society, which has been empowering for individuals with disabilities and has contributed significantly to the disability civil rights movement.

Unlike the biomedical model, the social model distinguishes between impairment and disability. Under the medical model, a person who is a wheelchair user is disabled regardless of the environment. Under the social model, if the same person is in a fully accessible and inclusive space, the individual would still have an impairment but *cease to be disabled* (Marks, 2002). This may seem similar to the environmental model but the goals are different. In the environmental model, the goal is to change the environment, whereas the sociopolitical model’s goal is civil rights and equal social status. While the environmental model wants to change the way society is built and constructed, the sociopolitical model wants to address the way people with disabilities are viewed and treated in society. This results in focusing not just on physical barriers, but attitudinal ones.

As the models of disability demonstrate, perspectives on disability vary significantly. While many people with disabilities embrace the sociopolitical model, the biomedical model is the dominant model in American society. As a result, people with disabilities experience immense prejudice and discrimination. In the next section, I explain the concepts of disableism and ableism and explore sources of prejudice and discrimination to provide a context of the culture in which college students with disabilities attend school and live.

**Disability in the U.S.A. (United States of Ability)<sup>2</sup>**

Throughout history, disability has been a universal part of the human experience. While the meaning and experience of disability has varied between cultures, it has been a part of every society in the world. However, as Smart (2008) notes:

Almost without exception, people with disabilities have been discriminated against, with that discrimination ranging from minor embarrassment and inconvenience to regulation to a life of limited experience and reduced social opportunity and civil rights. (p. 117)

In the most extreme cases of prejudice and discrimination, people with disabilities have been the victims of forced sterilization, institutionalization, and mass murder. In fact, some scholars have posited that people with disabilities have experienced more prejudice and discrimination than any other group in history (Davis, 1997; Smart, 2008). Davis (1997) claims, “People with disabilities have been isolated, incarcerated, observed, written about, operated on, instructed, implanted, regulated, treated, institutionalized, and controlled to a degree probably unequal to that experienced by any other minority group” (p. 1).

The prejudice and discrimination against people with disabilities is often termed as either “disablism” or “ableism.” Campbell (2009) defines disablism as “a set of assumptions (conscious or unconscious) and practices that promote the differential or unequal treatment of people because of actual or presumed disabilities” (p. 4). While some people use disablism and ableism interchangeably, Campbell (2009) argues there is a distinction between disablism and ableism, in which disablism focuses on the unfair and unequal treatment of people with disabilities whereas ableism is centered on able-bodied as the “norm” and thus disability is

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<sup>2</sup> United States of Ability was coined by Leonard Davis in his (2002) work, *Bending Over Backwards: Disability, Dismodernism, and Other Difficult Positions*.

something that must be fixed, cured, or rehabilitated if possible. Campbell (2001) defines ableism more specifically as:

A network of belief, processes, and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human. Disability is then cast as a diminished state of being human. (p. 44)

Smart (2008) states there are ten primary sources of disableism and ableism against people with disabilities. These sources of prejudice and discrimination are interconnected, and all of them have the potential to impact students with disabilities' experience in postsecondary education.

One source of prejudice and discrimination is the economic threat, which views people with disabilities as “burdens” or “drains” on the resources of the community (Smart, 2008, p. 128). In times of increasing scarcity, disability is viewed in terms of cost-benefit and cost-value ratios and the needs of people with disabilities are often labeled as too costly and not important. Furthermore, some temporarily able-bodied people stereotype people with disabilities as lazy freeloaders who do not want to work or contribute. In the worst scenarios, societies have embraced the economic threat to the point of implementing “cost-saving” measures such as forced sterilization, eugenics, and murder. In a capitalist society like the United States, the worth of a person is often determined by their potential economic value (Barnes & Mercer, 2010), causing many people with disabilities to be devalued.

A second source of prejudice and discrimination is the safety threat, which perceives people with disabilities as a threat to people without disabilities due to: “(1) violence, destructiveness, aggression, and antisocial behavior...and (2) contagion and contamination” (Smart, 2008, p. 138). The fear of violence is based primarily on the misconception people with

psychological and cognitive disabilities are dangerous and could “snap” at any moment and harm or kill other people. The fear of contagion grows out of the idea that people can “catch” disabilities from others. An excellent example of this is the polio epidemic, during which time infants, children, and adults with polio were isolated and quarantined unnecessarily due to the misconception that it was highly contagious (Smart, 2008). Similarly, many misconceptions and stereotypes currently exist about acquired immunodeficiency syndrome (AIDS), and people with AIDS are highly stigmatized as a result.

A third source of prejudice and discrimination is the perceived cause of a disability, which affects the amount of stigma a person with that disability experiences (Smart, 2008). Temporarily able-bodied people often seek ways to blame individuals for their disabilities (e.g., he should not have dived into that shallow pool; she would not be depressed if she would just try harder and get a control of herself). Smart (2008) claims,

The human tendency to blame the individual for his or her [sic] disability is an attempt to protect ourselves from existential angst or acknowledging the randomness of disability.

If we can believe the individual *caused* his or her [sic] disability, then we can comfort ourselves by saying, “We’ll never cause ourselves a disability.” (p. 173).

This phenomenon does not just occur with acquired disabilities—for example, sometimes the parents of children with disabilities are viewed as the cause of their children’s “suffering.” By assigning blame, temporarily able-bodied people can avoid responsibility and place all accountability on individuals with disabilities and their families.

A fourth source of prejudice and discrimination is the management of disability. Smart (2008) explains having a disability is a normative experience with a set of prescribed social rules and role expectations. Smart (2008) lists a number of rules, such as:

People with disabilities are to face their disability with...courage and optimism...self-mastery, emotional robustness, and resilience are all required...The individual should demonstrate the motivation and desire to recover, or at minimum, regain as many capabilities as possible. Active and independent management of the disability are expected...Individuals who adhere to medical regimens, who appear to “adapt” well to the situation, and who request only those necessary accommodations and assistance are subjected to less stigma than individuals who appear to not manage their disability well. (p. 182)

Ironically, people with disabilities are expected to actively manage their own disabilities while surrendering to medical treatment plans, resulting in two stereotypical roles of people with disabilities known as the “super cripp” and the “pathetic cripp” (Smart, 2008). As a pathetic cripp, the person with a disability is completely submissive to medical intervention. As a super cripp, the person with a disability makes having a disability look “not that bad”—in fact, super cripps are even considered inspiring for living with a disability.

A fifth source of prejudice and discrimination is the inferred emotional consequence of the disability. According to Smart (2008), “Inferred emotional responses...refer to the fact that most [people without disabilities] automatically assume that an individual’s disability is the worst thing that ever happened to the person, an unending, devastating personal tragedy” (p. 185). Having a disability is associated with extreme suffering, which promotes the “better dead than disabled” belief embraced by many in American society. Smart (2008) retorts “difficult does not mean tragic” (p. 184) and points to research that many people with disabilities would not accept a “cure” for their disability if it existed because their disability is not a tragic flaw but a part of who they are.



A sixth source of prejudice and discrimination is society's emphasis on beauty. American society highly values beauty, which is also associated with health, fitness, and sexuality. Smart (2008) observes, "Many people with disabilities are not viewed as being symmetrical, healthy, sexy, or physically fit." In fact, the more "unattractive" a disability is, the higher the degree of stigma. One of the most stigmatized disabilities is facial disfigurement, despite the fact that it comes with very few, if any, functional limitations (Smart, 2008).

A seventh source of prejudice and discrimination is the fear of acquiring a disability or existential angst (Smart, 2008). Disability is one of the most fluid identity factors, as people can become disabled at any moment throughout their life course by a number of causes (which are often uncontrollable or unexpected) such as illness and accidents. According to Longmore (2003):

Disability happens around us more often than we generally recognize or care to notice, and we harbor unspoken anxieties about the possibility of disablement to us, or to someone close to us. What we fear, we often stigmatize and shun and sometimes seek to destroy. (p. 132)

Ideally, if people recognized they could become disabled at any moment, they would become strong advocates for the civil rights of people with disabilities. Unfortunately, what often occurs instead is temporarily able-bodied people are driven by their fear and anxiety to minimize contact with or avoid people with disabilities as much as possible.

An eighth source of prejudice and discrimination is the ambiguity of disability, which is grounded in people's fear of the unknown and discomfort with uncertainty (Smart, 2008).

According to Smart (2008):

Disability, for many, appears to be ambiguous...the ambiguity leads to tension, discomfort, and ambivalence, all of which are unpleasant and the [person without a disability] often seeks to reduce or eliminate the ambiguity. There are two equal, but contrary, reactions to the [person with a disability]. On one hand, the observer feels intense aversion and hostility, but on the other hand, he or she [sic] also feels strong sympathy and compassion. (p. 142)

Due to the ambiguity of disability and resulting discomfort, temporarily able-bodied people may fear, misinterpret, stereotype, and avoid people with disabilities. They may also disempower people with disabilities by assuming they have greater limitations than they actually do—for example, people may assume someone with cerebral palsy is cognitively impaired due to limited or unclear vocal communication (Smart, 2008). The type of disability also affects how people respond to it—disabilities that are visible and do not change much over time (e.g., paraplegia) are less stigmatized than disabilities that are invisible and episodic (e.g., depression).

A ninth source of prejudice and discrimination is the concept of spread and overgeneralization, or “the widespread discounting and underrating of *all* of the ability of the individual with the disability” (Smart, 2008, p. 149, italics in original). For example, people without disabilities may view someone with dwarfism as immature or childlike simply because of their stature or talk slowly and loudly to a person who uses a wheelchair as if the person were also deaf and cognitively impaired. Smart (2008) notes that the most pervasive manifestation of spread is the “twisted body, twisted soul” concept, which assumes disabilities negatively impact people’s characters, making them mean, hostile, bitter, and irate. For example, temporarily able-bodied person may approach people with visible disabilities and ask, “What’s wrong with you?” When the person with a disability expresses irritation at this rude, invasive, and insensitive

question, people without disabilities will typically not recognize their own behavior as problematic but rather assume the person with a disability has a bad attitude and has not yet accepted or overcome the disability.

A tenth source of prejudice and discrimination, and the primary focus in this study, is temporarily able-bodied people viewing disability as the “master status” identity for people with disabilities—in other words, their disability defines them and nothing else matters. In National Public Radio’s (1998) feature “Inventing the Poster Child,” people share stories about how their disability is the most salient thing about them for other people, noting, “People meet you the disability before they meet you, “ and “You want to be yourself and the world asks you to be your disability.”

In general, the majority of people with disabilities report people without disabilities placing far more importance and salience on their disability than they do (Smart, 2008). Despite this, the pervasiveness of the master status ideology is so strong, it can become an identifier for people with disabilities. Lucy Grealy, a woman who had cancer and had numerous surgeries on her face claimed, “*I was my face. I was ugliness*” (Grealy, 1997, p. 19, as cited in Smart, 2008, p. 148, italics in original).

For many temporarily able-bodied people, the master status mindset is difficult to change. According to Jaeger and Bowman (2005), the master status role is so powerful that temporarily able-bodied people resist and reject any images of disability that contradict the view of disabled people as tragic, helpless, dependent, and disempowered. The master status also has the potential to render people with disabilities as not fully human. For example, Holman (2005) recounts when she went from using a wheelchair to walking with a leg brace, an able-bodied peer said to her, “You’re almost like a real person again” (p. 32).

Even professional service providers and academics studying disability sometimes ascribe to the “master status” ideology. For example, counselors and psychiatrists often assume the “presenting problem” for clients with disabilities is their disability (Smart, 2008). Fine and Asch (1988) critique scholarship on disability, lamenting:

To date all research on disabled [sic] men and women seems simply to assume the irrelevance of gender, race, ethnicity, sexual orientation, or social status. Having a disability presumably eclipses these dimensions of social experience. Even sensitive students of disability...have focused on disability as a unitary concept and have taken it to be not merely the “master” status but apparently the exclusive status for disabled [sic] people. (p. 3).

While the discipline of Disability Studies has made a great deal of progress, many researchers appear to continue (perhaps consciously or unconsciously) to use the master status narrative. For example, several works on disability identity development (e.g., Gibson, 2006; Kraus, 2008; Mackelprang & Salsgiver, 1999) provide the caveat that a disability does not define a person but then present a model or theory that primarily or solely focuses on individuals’ disabilities without regard to any other aspect of their identities or intersectionality.

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