

INSTRUCTOR'S EDITION

EIGHTH EDITION



RACE  
CLASS  
& GENDER

AN ANTHOLOGY

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## Race, Poverty, and Disability

### Three Strikes and You're Out! Or Are You?

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#### INTRODUCTION

Throughout the twentieth century, theories of biology and culture presented images of race, class, and disability in terms of deficiency and dependence. Biological models represented certain ethnic and racial groups as genetically inferior. Cultural models represented these groups as trapped in an inescapable cycle of poverty. Both models represented people of color with disabilities as social victims and/or socially threatening. Policies and practices based on these theories projected pejorative images on low-income ethnic and racial groups, and on people with disabilities. Individuals belonging to more than one of these categories—or all three—were especially vulnerable to social stigma.

Such images of biological and cultural pathology have been rejected by many modern theorists who have adopted a minority group model for the analysis of groups disenfranchised on the basis of race, class, gender, sexual orientation, and/or disability. In these formulations, racism, classism, ableism and other forms of prejudice create barriers that result in social and economic marginalization for members of disenfranchised groups. African Americans and Latinos with disabilities face multiple challenges of discrimination and social barriers related to race and class, as well as to disability. However, insufficient attention has been given to the interaction of these variables.

#### RACE, POVERTY AND DISABILITY AS BIOLOGICAL PATHOLOGY

From the time of the early eugenics family studies until eugenics' recent revival in academic and popular discussion, biological theories have always intersected theories of race, class, and disability. In the early 1900s, eugenics was the primary

ideological framework in which policies and practices were developed to manage marginalized populations. Eugenics, the science of the genetic improvement of the human race, was used to establish race and class distinctions as "natural" and incontrovertible. The dominance of the upper class was mandated by their superior genetic heritage; the poor remained in poverty because of their degenerate genes.

Many proponents of eugenics believed in a hierarchy of "lower" and "higher" races. These theorists sought a state-controlled program to improve the quality of the human gene pool by optimizing the breeding of elite white Anglo-Saxon Protestants (positive eugenics), and controlling the reproduction of "degenerates," "morons," and those of "inferior" racial or ethnic groupings (negative eugenics). Special attention was given to those of "mixed" heritage and to foreigners from places other than Western Europe. "Mongrel" families (mixed Caucasian, African-American and Native American racial heritage) were considered unstable and degenerate. The genetic inferiority of the new wave of immigrants was widely discussed. Alarmed at the supposed decrease in the birthrate of white Anglo-Saxon Protestants, eugenicists feared "race suicide." One psychologist advocated that "morons" be allowed to serve in the army in World War I, so that fewer "normal men" would be wasted.

Eugenicists believed that racial degeneration would change the national character, subsuming a primarily Nordic-European population under a "tide" of unwanted immigrants. Adherents of the biological-pathology model developed standardized tests that they believed proved the inferior intelligence of African Americans and immigrants. The biological model highlighted multiple stigma as justification for regressive social policy. Some case studies showed how racial character, poverty, and disability interacted with other factors such as illicit pregnancy, prostitution, gambling, alcoholism, drug addiction, tuberculosis, and syphilis. When several of these factors coexisted, it was considered an indication of degeneration due to pathological inheritance. Policymakers and high profile health professionals in the United States responded by establishing programs for the institutionalization and sterilization of supposedly pathological populations. Hundreds of thousands of individuals considered "feeble-minded" were institutionalized, sometimes for life, in facilities that still exist today.

The extreme example of both positive and negative eugenics was Nazi Germany. Those with Aryan characteristics were encouraged to have large families, while thousands of others were involuntarily sterilized and millions of others were annihilated under a policy of racial purification. Advances in the science of genetics and the example of Nazi Germany served to discredit the eugenics movement in the United States. However, eugenicists continued to take an active role in many professions, including population science and social service provision for marginalized groups (e.g., people on welfare, psychiatric patients, and people with cognitive disabilities).

The term "eugenics" disappeared from professional and popular discourse when it was discredited and thus no longer considered an effective means of program implementation. However, decades after eugenics disappeared from official public policy, eugenicists continued to influence the social service system

by advocating institutionalization and sterilization of people with developmental disabilities and sterilization of women on welfare. The legacy of treatment models developed by eugenicists in the early 1900s (such as segregation from the opposite sex and sterilization) is still apparent in practices, such as genetic counseling, which encourage the abortion of fetuses with disabilities like Down's Syndrome. It is also visible in the physical and organizational structures of mental institutions and in the psychological scars of people who have been institutionalized for long periods. Additionally, eugenics ideologies persisted through the subtle influence of cultural beliefs concerning marginalized groups, evidenced by contradictory representations of people with disabilities in literature, film, and television as social victims or social threats. People with disabilities are often portrayed as unable to control their sexuality and capable of erupting into random and unpredictable acts of violence. Society and those with disabilities are only considered safe when such people are locked behind the walls of an institution or when deceased.

### **RACE, POVERTY AND DISABILITY AS CULTURAL PATHOLOGY**

In the 1930s, biological theories began to be replaced by the theories of culture promulgated by sociologists and anthropologists. Various views of poverty were presented: as cultural disintegration and deprivation; as inspiring pathological forms of cultural structure, i.e., the "culture of poverty"; or as a result of the loss or lack of culture.

Although recognizably distinct from earlier biological theories, the new cultural theories included regressive images of people living in poverty that were disturbingly close to earlier models. Whether the explanation was biological or cultural, these differences (e.g. to be poor, a racial minority, or to have a disability) were presented as a form of self-defeating and self-perpetuating pathology.

Whether defined as a pathological lack of culture, or a culture that was pathological, the people living in poverty were considered deficient by leading theorists and in public policy. For example, the concept of "culture of poverty" impacted Department of Labor and War On Poverty thinking in the 1960s.

The prevalence of the deficiency approach has also characterized societal perceptions of people with disabilities. For example, the 1994 reauthorization of the Developmental Disabilities Assistance and Bill of Rights Act (PL 103-230), defined developmental disabilities as a series of "substantial functional limitations" in "self-care," "self-direction," "capacity for independent living," and "economic self-sufficiency." These "substantial functional limitations" were also exhibited by the "white trash" in an earlier period, with biology thought to be the root cause. Like pathological genes, the culture of poverty was reproduced from generation to

cultural pathology to supplant eugenics notions of biological pathology. Thus the social problems exhibited by minorities, such as teen pregnancy, alcohol and drug abuse, welfare culture, serial monogamy or multiple partners, and destabilized families, could be explained through cultural, rather than biological deficiencies. Whether in biological or cultural terms, the contours of these pathology arguments were quite comparable, focusing on the identification of individual deficits and blaming the victim for having them.

### **FROM MINORITY GROUP MODEL TO AN EMPOWERMENT FRAMEWORK OF ANALYSIS**

Immediately after their appearance, scholars and activists began challenging the concepts of the culture of poverty and cultural deprivation, protesting that the supposed traits of people living in poverty were contemptuous distortions based on middle-class biases. Urban anthropologists wrote ethnographic accounts of African-American communities highlighting and valorizing cultural differences. Community, social, and developmental psychologists suggested that so-called "deficits" in language and learning actually reflected cultural differences, not cultural deficiency. Activists protested an approach that blamed victims for their problems and ignored the strengths of their cultures.

Like the eugenics family studies, the culture of poverty thesis functioned to justify blaming the poor for their poverty and blaming social problems on innate deficiencies. Culture became an alternative to biological explanations for the inferiority, dependency and marginality of certain social groups. Individuals from marginalized groups became categorized as mentally retarded, not because of their inherent "incompetence," but due to racial and class bias within school and social service systems.

The contrary view claimed that social problems should be addressed through the elimination of unequal power relations and re-distribution of wealth and income. This social perspective on disability is based on a minority group model that has also been adopted to explain systematic exclusion on the basis of sex, race, and sexual orientation. This model functions to liberate individuals with disabilities from long-held societal prejudices and mistaken assumptions.

Identity politics grew out of collective movements for equality on the basis of gender, race, and sexual orientation. People with disabilities are now applying this principle to their own situations. However, within the minority group model, a single issue (such as race, gender, or sexual orientation) is usually the focus for identity formation. Other issues are considered secondary or are not considered at all. Perhaps this is a response to earlier biological and cultural models that tended to use a multi-issue approach to "prove" the pathological nature (and culture) of marginalized groups. In the process of identity formation, attempts to stay as far away from the earlier pejorative images of race and poverty have resulted in the inadvertent exclusion of individuals facing the "triple jeopardy" of race, poverty, and disability. Perhaps to overcome the pressures of

marginalization and to rally a critical mass of support, it is more effective, especially initially, to focus on one common characteristic. But inevitably to some degree this single-focus strategy excludes those facing triple jeopardy and their multiple concerns.

Disability rights activists reject earlier models of disability, adopting instead a model that emphasizes overcoming social barriers rather than focusing on individual pathology. In contrast to static biological and cultural models, the minority group model is a dynamic view of disability resulting from the interaction of the individual and the environment. Disability-rights activists argue that social and cultural values encouraging discrimination or the segregation of people with disabilities must be changed. In this model, the emphasis shifts from the individual to the society, and from victim-blaming to strategies for social change. Education, organizing, a sense of community, and pride in identity replace earlier experiences of isolation and shame. Individuals can band together with others who face similar challenges and learn how to challenge and navigate existing systems to their advantage. A good example is the national advocacy organization of people with physical disabilities known as ADAPT ([www.adapt.org](http://www.adapt.org)). This organization originally focused on efforts to make public transportation accessible in major cities in the country. Since the passage of the Americans with Disabilities Act, the group has focused more on efforts to promote state and national legislation regarding needs for personal care attendants. This group tends to approach social change one-issue-at-a-time.

Earlier biological and cultural models focused on individual pathology, thus obscuring the significant social barriers faced by people with the multiple stigmas of race, poverty, and disability. With multiple stigmas (such as gender, race, and disability), opportunities for employment become increasingly limited and people become trapped in poverty. Disability, poverty, and minority status are linked and intensify the already negative relationship between economic status and the existence of a disability. For example, the majority of Latinos with disabilities live below the poverty level, and African Americans with disabilities are particularly disadvantaged. Biological and cultural theories cannot sufficiently explain the discrepancies between the disabled and non-disabled, minority and non-minority populations. People living with multiple stigmas have limited opportunities and resources available to them and face societal barriers and oppression that result in poverty and exclusion.

An empowerment framework, one that refers to the increased degree of control people can have over relevant aspects of their environment, better accounts for systemic inequalities faced by minorities with disabilities and attempts to overcome these obstacles.

The minority group model of disability must encompass the complex and multilayered identities held by people with disabilities. For some individuals, disability is only one of many stigmas they face. A disability-rights model that does not recognize the multiple barriers resulting from the "triple jeopardy" of race and disability may inadvertently exclude a large number of peo-

for social change. An empowerment framework of analysis that incorporates an understanding of multifaceted issues can serve as a catalyst for helping people to overcome multiple stigmas and support their efforts to seek positive social change.

This framework encourages people from multiple constituencies to develop a common agenda based on shared unmet needs. It also promotes self-reliance and an increased awareness and understanding of the social forces that maintain oppression and discrimination. Empowered individuals or groups are more likely to challenge the status quo and to pursue remedy to the social inequality that characterizes the existence of low-income people of color with disabilities.

## CONCLUSION

Throughout the twentieth century, several models have evolved to address the problems of people from marginalized groups, such as those living in poverty or who have disabilities. In the early decades of the twentieth century, a model of biological pathology was used to explain persistent social problems, and pathological inheritance was believed to cause mental and physical deficiency. In the decades following World War II, biological explanations gave way to models of cultural pathology. Cultural deprivation was related to mental and physical deficiency, resulting in deficits in language and learning. Both biological and cultural pathology models have been criticized for over-looking the importance of social and political inequality. The minority group model was developed in the 80s and 90s to explain the persistence of the social barriers faced by people with disabilities and other marginalized groups. Currently, an empowerment framework re-conceptualizes the problem and specifies action sequences by which individuals from marginalized groups with multiple stigmas may gain the social, political, and economic support needed to overcome barriers to their full participation in society.

Early perceptions of people with disabilities as victims and threats have been increasingly replaced by images of social actors empowered to and capable of overcoming functional limitations and social barriers. Attempts continue to be made to better understand the complex interaction of multiple variables, such as disability, gender, race, and economic status. Developing theories of social change support the promotion of empowerment. Minorities with disabilities living in poverty can have the strength, understanding, and motivation to learn about their own situation and act to change it. They can develop a critical consciousness about their oppressed status, and then plan and take action to address the impact of negative societal attitudes on them and others in similar circumstances.

The barriers faced by people of color with disabilities living in poverty should not be underestimated. Racism, ableism, and poverty severely limit opportunity. Established organizations are usually unprepared to serve minority populations with multiple needs. For example, there is a growing population of

inner-city minorities who have become permanently disabled as a result of violence. Service providers have difficulty meeting their needs. In the past, such situations were addressed through single-issue movements, and service provision that divided and dealt with each issue in isolation.

What is needed now is greater implementation of empowerment approaches that address the nexus of race, poverty, and disability. With critical awareness, support and social change, individuals and groups facing multiple stigmata need not be relegated to the sidelines of society. Essential to this important mission are more indigenous leaders and grassroots groups who have experience working on these different levels to meet the needs, affirm the rights and enhance the choices of people of color with disabilities living in low-income neighborhoods. Three strikes need not mean you're out, but rather playing a game with a greater degree of difficulty.