Enabling the language of accessible tourism

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ABSTRACT

The growing body of literature on "accessible tourism" lacks a critical scholarly debate around its specific language use and nomenclatures. To fill this gap, this paper provides a first examination of language. Language provides a unique capability to resist, strengthen and reframe identities of individuals and groups, yet can also reinforce, weaken and perpetuate dominant worldviews of disability. A content analysis examined previous accessible tourism literature with results illustrating that diversity exists amongst the varying terminologies adopted by scholars. Terms were employed loosely, inconsistently and interchangeably, euphemistically with erroneous understandings and nuances. The paper concludes with critical discussion about the power of researchers to (re) produce oppression through language that maligns and misrepresents, or to (re) conceptualise and (re) construct the world we live in with liberating language that facilitates positive social change.

Introduction

Language has the power to create, describe, condone or justify attitudes and behaviour. Unfortunately, many of the descriptors of disability manifest continual discrimination, prejudice and stigma (Goffman, 1963; 2009). The language employed by an individual, organisation, group or society illustrates how "it simultaneously mirrors and constructs cultural values ... [and is] appropriated by powerful social groups" (McClimens, 2007, p. 264). The choice of language employed by the media to describe an individual with a disability, for example, defines, prescribes and restrains their identity, while ignoring other key aspects of an individual's life story that do not easily fit into the dominant culture's preferred narrative of disability (Haller, Dorries, & Rahn, 2006; Jones & Harwood, 2009). These discursive framing and rhetoric techniques work at both unconscious and conscious levels (Paterson, Coffey-Glover, & Peplow, 2016). They construct an identity that has powerful institutional and social consequences for shaping the attitudes, perceptions, responses and actions directed at that individual (Augoustinos & Every, 2010; Paterson et al., 2016). Gaining control of language then, is crucial for resisting particular meanings to describe disability, to challenge detrimental perspectives that dominate society, and perhaps more importantly, claim new meanings.

In this paper, we argue that tourism scholars need to be mindful of the language adopted and considerate of the discursive aspects of their work when studying this area of scholarship (Peters, 1999). This paper positions language as an important component in the pursuit of social sustainability and within the wider discourses of sustainable tourism and accessibility (Darcy, Cameron, & Pegg, 2010). Describing and labelling is a process to "establish control ... [and] there is a need to debate a

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suitable form of descriptors that will identify and promote the humanity of labelled individuals above the matrix of psychosocial and medical diagnoses. And any such description begins with the right words" (McClimens, 2007, p. 259). As critical tourism scholars, we need to ensure we role model as well as embody and deliver the language of hope and possibility (Higgins-Desbiolles & Powys-Whyte, 2013) – how we talk effects how we think, and how we think effects how we act; we need to talk the walk, as well as walk the talk. A caveat needs to be made here, however, a common acquiring of, or change in, language adoption cannot be recognised as a panacea for social change, at least quickly. Instead, progress could be made towards removing barriers and creating enabling environments for people with disabilities, if purposeful and reflective consideration of language was undertaken (Titchkosky, 2003). Within this context, this paper seeks to offer an original contribution, in providing a first and critical examination of the language used in previous studies of accessible tourism to consider an agenda for social change. The study posed three research questions. First, what language has been used in "accessible tourism" scholarship? Second, what reasoning do scholars offer, if at all, for their use of language? Third, what are the implications of this language use on the discourse of "accessible tourism" and social change?

Toward socially constructed understandings of tourism

Arguably, one of the greatest constraints facing people with disabilities is attitudinal barriers (Daruwalla & Darcy, 2005), and particularly "linguistic oppression" (Corker, 2000, p. 447). An integral part of the hostile attitudes expressed to and about people with disabilities is the labelling and stigma associated with language (Jaeger & Bowman, 2005; Susman, 1994; Titchkosky, 2003). Indeed, within the discourses of disability, previous research aligned with the medical or individual model of disability has been criticised for its prioritising of the impairment first before the individual, thereby perpetuating the notion of loss, tragedy or abnormality, and serving as the basis for many negative and limiting attitudes, policies and outcomes (Darcy & Buhalis, 2011b; Oliver, 1990). In this way, labels such as "handicapped", "mong", "spastic" and "retard" have been used as derogatory and hurtful terms to emphasise notions of deficit that dominate the medical model worldview (Grue, 2011). In contrast, the social model of disability has challenged the discourse of the medical model, arguing that society disables the individual through the socially constructed environment that excludes people with disabilities from participation (Oliver, 1990). Thus, provision of necessary services and support to minimise or remove barriers, collective change and wider social action is required to enable the full participation of people with disabilities into all aspects of citizenship (United Nations, 2006; World Health Organization, 2012, 2013). Yet, even within the social model, there too has been contention over language that causes generalisations about people with disabilities and challenges raised between different terms, such as "disabled person" and "person with disabilities". The former term being most commonly cited alongside the United Kingdom's social model, with the latter term being most commonly cited alongside rights-based approaches, for example, the United Nations Convention on the Rights of Persons with Disabilities, which was adopted on 13 December 2006 and ratified on 3 May 2008 (Harpur, 2012a; World Health Organization & The World Bank, 2011). Regardless, we could dispute that individuals with some form of impairment are marginalised, or "disabled", not just by the disabling nature of attitudes and environments, but by any labels given to them.

Underpinning the two dominant conceptualisations of disability has been the distinction between "impairment" and "disability" (Harpur, 2012a). The difference between the two terms was in fact the bases of the origins of the social model of disability, where the latter term focused primarily on the socially constructed nature of disability, and resulting exclusion (Oliver, 1990). "Impairment is any loss or abnormality of psychological, physiological or anatomical structure or function… Disability is any restriction of lack (resulting from an impairment) or ability to perform an action in a manner, or within the range, considered normal for a human being" (Darcy & Buhalis, 2011a, p. 24). Impairment, therefore, is the resulting loss of function, and disability is the identified restriction or lack of ability to perform an action resulting from the impairment (World Health Organization, 2012, 2013). Defined

mostly in accordance with descriptions presented by the World Health Organization's (WHO) International Classification of Impairments, Disabilities and Handicaps (1980) and United Nations Enable (2009), the definitions are based on a range of normative assumptions, and Darcy and Buhalis (2011a) point out that both definitions focus on the loss or deficits of the individual, by referring to their physical or cognitive limitations. During the 1990 s, the WHO provided a universal bio-psycho-social classification system in an attempt to unite the medical and social models of disability and provide a common language for information systems and scientific enquiry (World Health Organization & The World Bank, 2011). However, the system extends controversy amongst disability studies theorists, as the foundation remains based on the spectrum of diseases, disorders and medical conditions (Andersson, 2006; Darcy & Buhalis, 2011b; Hammell, 2004; Imrie, 2004). As such, it is important to note that commonly cited definitions can perpetuate the dominant worldview of the medical model of disability, which historically, has tended to inform much legislation and policy (United Nations, 1993). As alluded to above, the social model does not deny a person's impairment but seeks transformation of the "impaired person" to a "disabled person" as a result of ways in which society is organised as discriminatory (because it is based on a non-disabled interpretation of what is considered "normal"). It therefore places disability in an inaccessible economic, physical, political and social world (Barton, 1998; World Health Organization & The World Bank, 2011).

As an alternative concept, "accessibility" is being increasingly used in a purposeful move away from a sole focus on "disability". This can be evidenced within tourism studies wherein we have seen a progression from concepts of "barrier-free tourism", "disabled tourism", "easy access tourism", "inclusive tourism" and "tourism for all" to the more recent concept of "accessible tourism" (Darcy & Buhalis, 2011a). Indeed, many issues of disability and tourism are now discussed under the term accessible tourism, defined as

> … a form of tourism that involves collaborative processes between stakeholders that enables people with access requirements, including mobility, vision, hearing and cognitive dimensions of access, to function independently and with equity and dignity through the delivery of universally designed tourism products, services and environments. This definition adopts a whole of life approach where people through their lifespan benefit from accessible tourism provision. These include people with permanent and temporary disabilities, seniors, obese, families with young children and those working in safer and more socially sustainably designed environments. (Darcy & Buhalis, 2011a, pp. 10–11)

With an emphasis on the socially constructed nature of this type of tourism, the concept of accessible tourism is encompassing of a broader range of access requirements, wider than those who we classify as having a disability, and considerate of a whole-of-life approach to embodiment. The words "access" and "accessibility" have often been viewed as taken-for-granted yet complex concepts, with different meanings in different contexts (Darcy & Dickson, 2009; Eichhorn & Buhalis, 2011; Iwarsson & Stahl, 2003; Jensen, Iwarsson, & Stahl, 2002). The terms have not been used with consistency and have mostly been applied in the consideration of constraints and standards for dimensions of information, physical and social accessibility (Iwarsson & Stahl, 2003).

Despite calls for common language, there remains little effort to address this concern and previous research on accessible tourism has not yet engaged in a critical discussion of language (Eichhorn & Buhalis, 2011; Iwarsson & Stahl, 2003). Within the literature on accessible tourism, terms such as "disabled people", "people with disabilities", "impairment" and "disability", among others, seem to be used interchangeably and inconsistently. Ambiguous and unquestioned language could further perpetuate the societal barriers faced by people with disabilities.

Study methods

A content analysis was carried out on a sample of 122 scholarly English-language publications derived from an extensive database search on "accessible tourism". Google Scholar was selected as an efficient and successful discovery and retrieval tool (Jacsó, 2005; 2008; Moed, Bar-Ilan, & Halevi, 2016), in addition to our University's repository, which features subscriptions to extensive and
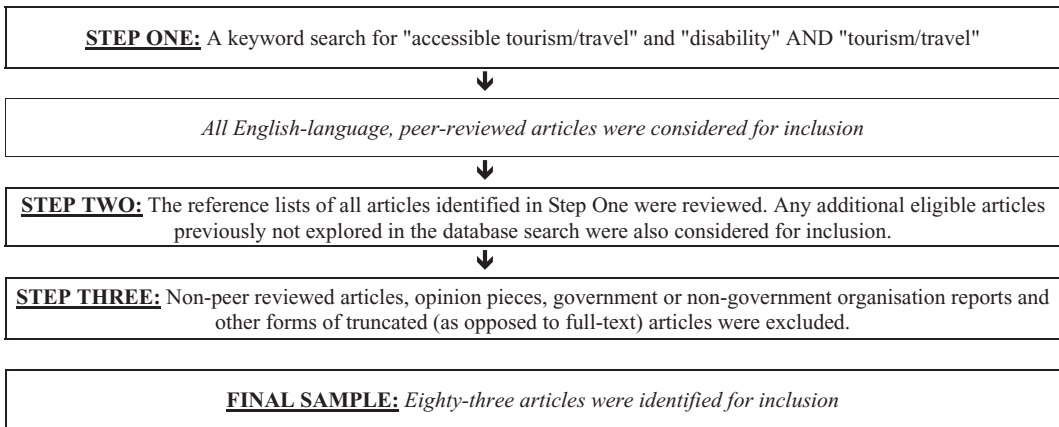
STEP ONE: A keyword search for "accessible tourism/travel" and "disability" AND "tourism/travel"	

⬇

All English-language, peer-reviewed articles were considered for inclusion

⬇

STEP TWO: The reference lists of all articles identified in Step One were reviewed. Any additional eligible articles previously not explored in the database search were also considered for inclusion.

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STEP THREE: Non-peer reviewed articles, opinion pieces, government or non-government organisation reports and other forms of truncated (as opposed to full-text) articles were excluded.

FINAL SAMPLE: *Eighty-three articles were identified for inclusion*

Figure 1. Steps to identify articles for content analysis.

multiple databases, including Scopus and Web of Science. A content analysis sees the reduction of a volume of qualitative "textual" data through the creation of a set of codes, in an attempt to identify and make sense of recurring words, patterns or themes (Krippendorff, 2012; Patton, 2002). Quantitatively, we sought to determine the presence of certain terminology and concepts broadly pertaining to "disability" and "tourism", in the form of numerical frequency counts. Applied to tourism studies, the empirical study of content of literature provides grounded evidence of trends, the evolution of knowledge, identifies patterns in concept development, and can critically review discourse on contemporary definitions and measurements (Xiao & Smith, 2006). Previous scholars have effectively used content analysis to review and critique published literature to explore developments in the concept of "sustainable tourism" (for example, Lu & Nepal, 2009). We also explored and synthesised the qualitative dimensions of the data, in terms of comprehending a sense of intentionality, if any, in the implementation of such terminology and concepts and their wider implications on language and discourse. Hence, the data was categorised by the terminology employed and the consistency of that employment, and in terms of the engagement offered, coded as Terminology, Context, Discourse or Participant (see Figure 1). As we were working to unveil the implicit and relational, as well as the conceptual, the analysis was carried out by the first two of the four authors, manually as opposed to using a computer-based text analysis software package (Ely, Anzul, Friedman, Garner, & McCormack Steinmetz, 1991). By reading through the text and systematically recording and coding the data into manageable categories, we could make valid inferences and interpretations about the language of accessible tourism scholarship, or be it the descriptive nature of content analysis outputs is acknowledged. To ensure reliability of the analysis, coding was undertaken separately by two of the authors and frequent discussions were held about coding issues, questions and discrepancies, and spot-check comparisons of coding made (for example, Lu & Nepal, 2009).

The final sample of scholarly English-language publications comprised 39 book chapters, accounting for 33% of the total sample, in addition to 83 scholarly journal articles and conference papers, accounting for 77% of the total sample (see Table 1) The book chapters were sourced predominantly from two foundational edited books on accessible tourism, namely *Accessible tourism: Concepts and issues* (see Buhalis & Darcy, 2011) and *Best practice in accessible tourism: Inclusion, disability, ageing population and tourism*) (see Buhalis, Darcy, & Ambrose, 2012). The journal articles and conference

Table 1. Sample.

	Book chapters	Journal articles
Number	39	83
Percentage	32%	68%
Total		122

Table 2. Context of the research.

Region	Countries	Number	Percentage
Africa	South Africa	1	<1%
Asia	Hong Kong; Indonesia; Macao; Malaysia and South Korea	9	7%
Australasia	Australia and New Zealand	25	21%
Europe	Austria; Belgium; Denmark; Finland; France; Greece; Italy; Norway; Poland; Portugal; Slovenia; Spain; Sweden and Turkey	23	19%
Middle East	Dubai; Israel; and Jordan	6	5%
North America	Canada and United States of America	20	16%
Other	General; Global or Varied	25	21%
United Kingdom	England	13	11%
Total		122	100%

papers broadly traverse the disciplines of business, disability, hospitality, leisure, social sciences and tourism, with all retrieved publications published within the last 13 years (from 2003 to 2015), apart from three (see Abeyratne, 1996; Murray & Sproats, 1990; Smith, 1987). As Table 2 shows, the sample was derived from the following regions and countries: Africa (South Africa); Asia (Hong Kong, Indonesia, Macao, Malaysia, and South Korea); Australasia (Australia and New Zealand); Europe (Austria, Belgium, Denmark, Finland, France, Greece, Italy, Norway, Poland, Portugal, Slovenia, Spain, Sweden, and Turkey); the Middle East (Dubai, Israel, and Jordan), North America (Canada and the United States of America); and, the United Kingdom (England). An "other" category was assigned to any articles that either did not specify a particular geographic location, included an assortment of different countries, or were written in reference to a general context or global setting. This grouping comprised of 25 publications (or 21% of the total sample). Australasia also comprised of 25 publications (or 21% of the total sample), Europe followed with 23 publications (or 19% of the total sample) and North America with 20 publications (or 16% of the total sample).

The major limitation of this study is that the literature search was restricted to English-language scholarly publications. Over the last decade there has been a growing body of scholarship on disability, tourism and accessible tourism (or other closely related areas) emanating from China, France, Latin America, Portugal and Spain that are written in languages other than English. These contributions to our conceptualisations and understanding of the contexts of global language involving disability and tourism are not incorporated into this study. However, in recognising this limitation of the study we also recognise the complexity of each language context, the way disability is positioned within these cultural contexts, and that the nature of language expression would not be comparable across language groups. A further limitation is that this study did not consider the Journal Impact Factor or Citation Impact Factor of the journals and scholars' who authored these papers, nor cities or countries where most accessible tourism research has been covered, respectively. While these represent possible future research directions, it was not the intention of this study to focus on the particular scholar, paper or journal, or destination, and their level of diffusion or impact. Rather, the focus was on the broader provision of an account of the language presented in the field, and to this end, all articles were weighted to the same value. Given the significance of language within the disability studies literature, we argue that language and discourse has applicability not only within academia (in terms of how and why it is being employed, rather than by who), but also beyond, for example, in policy and legislation.

Study findings

The language of accessible tourism scholarship

Given the explicitly strong relationship between *disability* and *tourism* (Darcy & Buhalis, 2011a; Darcy & Dickson, 2009; Darcy, Cameron, & Schweinsberg, 2012), the publications analysed were first grouped according to these two categories and then further broken down to include sub-categories.

Table 3. Terminology: disability categorisation – adjective-first terminology.

Adjective-first terminology			
Disabled children	1	*Disabled population*	*12*
Disabled community	5	Disabled staff	1
Disabled consumers	3	*Disabled tourist/s*	*16*
Disabled customers	6	*Disabled traveller/s*	*16*
Disabled demographic	1	Disabled user/s	3
Disabled employees	2	Disabled visitors	2
Disabled guests	4	Disabled workers	1
Disabled holiday-makers	2	Impaired persons	1
Disabled individuals	3	Handicapped person	1
Disabled member	1	Marginal tourists	1
Disabled passengers	2	Special needs	2
Disabled people	*31*	*(The) disabled*	*11*
Disabled person/s	*12*		

The *disability* categorisation included *adjective-first terminology* (see Table 3)*, person-first terminology* (see Table 4)*, non-disabled terminology* (see Table 5) and *dimensions of disability* (including hearing, cognitive/intellectual/learning, mental health, mobility, multiple, sensitivities and vision) (see Table 6). The *tourism* categorisation included *type of tourism* (see Table 7) and *tourism market* (see Table 8). The content analysis revealed a proliferation of terms that were used to describe the nexus of disability and tourism. An assumption was made that the terms most often used (shown in italics in the tables), were likely those reflecting the culture in the communication space of accessible tourism. The numbers are indicative of the number of articles who employed such descriptors. For example, "people with disabilities 77" suggests that seventy-seven articles from the sample used this descriptor at least once. Within the *disability* categorisation, several terms were used loosely, inconsistently and interchangeably, effectively referring to, or describing, the same individual or group; and often supporting

Table 4. Terminology: disability categorisation – person-first terminology.

Person-first terminology							
Adults with disabilities	1	*Individuals with disabilities*	*13*	People with impairments	4	Tourists with special needs	1
Athletes with disabilities	1	Less mobile traveller	1	People with less ability	1	Travellers with a disability	2
Children possessing disabilities	1	Others with accessibility needs	1	People with special needs	2	Travellers with an impairment	1
Consumers with disabilities	2	Parents of children with disabilities	1	Person/s with (a) disability	4	*Travellers with disabilities*	*14*
Customers with disabilities	5	Passengers with disability	1	*Person/s with disabilities*	*18*	Travellers requiring access	1
Customers with special needs	3	Passengers with disabilities	1	Persons with impairments	1	Travellers with special needs	1
Employees with disabilities	3	Patron with disabilities	1	Population with disabilities	2	Users with disabilities	1
Family member with a disability	1	People living with a disability	1	Those with disabilities	3	Visitors with access needs	1
Families of children with disabilities	1	People with access needs	1	Tourists who are disabled	2	Visitors with disabilities	2
Families with a member who has/ with a disability	2	People with access requirements	2	Tourists who have disabilities	1	Visitors with disability	1
Families with disabilities	1	People with different impairments	1	Tourists with a disability	8	Women with disabilities	1
Guests with disabilities	5	*People with disabilities*	*77*	Tourists with an impairment	1		
Individuals with (a) disability	5	People with (a) disability	10	*Tourists with disabilities*	*23*		

Table 5. Terminology: disability categorisation – non-disabled.

Non-disabled			
Able-bodied	4	Non-disabled person	1
Able-bodied guests	1	Non-disabled tourists	2
Able-bodied people	1	Non-wheelchair users	2
Able-bodied persons	3	Ordinary users	1
Able-bodied population	1	Others without disabilities	1
Able-bodied tourist/s	2	People of all abilities	1
Able-bodied travellers	3	People without access requirements	1
Able-bodied visitors	1	*People without disabilities*	13
Citizens without mobility restrictions	1	People without impairments	1
Customers without mobility impairments	1	Persons without a disability	1
Families without a member with a disability	1	Population without disabilities	1
Fully abled counterparts	1	Sighted guides	2
Healthy older adults	1	Sighted peers	1
Hearing people	1	Sighted people	1
Individuals without disabilities	1	Sighted tourists	2
Mature travellers without disabilities	1	Sighted traveller	1
Non-disabled	4	Those without disabilities	2
Non-disabled customers	1	Tourists without disabilities	1
Non-disabled individuals	1	Women without disabilities	1
Non-disabled people	2	Younger counterparts	1

the same positions argued in disability discourse (Titchkosky, 2003). In *adjective-first terminology,* employed most repeatedly were the terms: "disabled people" (31); "disabled tourists" (16) and "disabled travellers" (16). In *person-first terminology,* employed most repeatedly were the terms: "people with disabilities" (77); "tourists with disabilities" (23) and "persons with disabilities" (18). Within *non-disabled terminology,* employed most repeatedly were the terms: "people without disabilities" (13); "able-

bodied people" (7) and "able-bodied tourists" (3). The analysis revealed 152 different terms used to describe the various *dimensions of disability*. Within each sub-categorisation, the most predominant were: *hearing* – "deaf people" (3); *cognitive/learning/intellectual* – "individuals with an intellectual disability" (2); *mobility* – "wheelchair user" (13); *multiple* – "people with acquired disabilities" (2) or "people with diverse disabilities" (2); and *vision* – "blind people" (7). *Type of tourism* saw the prominent use of "accessible tourism" (41); "tourism for people with disabilities" (6); and "accessible travel" (4). To a lesser extent, *tourism market* included recurrent use of terms: "accessible tourism market" (6); "accessibility market" (3); "disability market" (3) and "seniors market" (3).

The level of consistency in scholars' employment of language was also explored and rated as "no consistency", "moderate consistency" or "good consistency". The content analysis revealed that 48 publications (or 39% of the total sample) provided "no consistency" in their employment of language; 35 publications (or 29% of the total sample) provided "moderate consistency" and 39 publications (or 32% of the total sample) provided "good consistency". As an example of moderate consistency, one publication used the following diverse terms to describe non-disabled people and people with disabilities: "able-bodied customers"; "non-disabled customers"; "customers with disabilities"; "disabled customers"; "disabled people as consumers"; "people with disabilities"; "the disabled" and "travellers with disabilities". As an example of good consistency, one publication used consistent terms of "accessible tourism"; "people with(out) access requirements" and "people with(out) disabilities". Of note, the example of moderate consistency given above uses terminology from both adjective- and person-first language, thereby blurring the philosophy underlying the dominant models of disability discourse. In contrast, the second example uses terms firmly aligned to person-first philosophy and the social model of disability. Whilst we cannot necessarily presume that terms are used carelessly or unknowingly by scholars, we can

Table 6. Terminology: disability categorisation – dimensions of disability.

Dimensions of disability

Hearing

n	Term
1	Deaf clients
1	Deaf individuals
2	*Deaf people*
1	Deaf tourists
2	Disabled people with hearing and speaking problems
1	Guests who are deaf
1	Guests who are hard of hearing
3	*Guests with (a) hearing impairment/s*
1	Hearing-impaired
1	Hearing-impaired person
1	People who are deaf
1	People who have hearing impairments
1	People who were deaf
1	Person with hearing impairment
1	Users with hearing impairments
1	Visitors with hearing impairments

Intellectual, cognitive and learning

n	Term
1	Autistic
1	Consumers with developmental disabilities
2	Family member with a developmental disability
1	*Individuals with (a/an) intellectual disability*
1	Individuals with developmental disabilities
1	People who have cognitive disorders
3	People with cognitive impairments
1	People with dementia
1	People with developmental disabilities
1	People with intellectual impairments
1	Person with dementia
1	Persons with developmental disabilities
1	Visitors with restricted perceptibility
1	Young disabled people with cerebral palsy

Mental health

n	Term
1	Disabled people with mental problems
1	Respondents with mental disabilities
1	Tourists with mental disability
1	Family member with dementia
2	*Individuals with (a/an) intellectual disability*

Mobility

n	Term
1	Adults with mobility impairments
1	Athletes with mobility disabilities
1	Crutch/es users
1	Disabled people with walking problems
1	Disabled people with wheelchairs
1	Guests with a bodily impairment
1	Guests with a walking impairment
1	Guest with impaired mobility
2	Guest with mobility impairment/s
1	Guests with physical disabilities
1	Guests with walking difficulties
1	Guests with wheelchairs
1	Impaired-mobility guests
1	Individuals with mobility disabilities
2	Individuals with mobility impairments
1	Individuals with physical disabilities
1	Mobility-challenged
1	Mobility-disabled
1	Mobility-impaired consumer/s
1	Mobility-impaired individuals
1	Mobility-impaired people
2	Mobility-impaired person/s
1	Mobility-restricted individuals
2	Participants using crutches
1	Participants using wheelchairs
1	Participants with mobility impairments
1	Passengers with mobility limitations
2	People who were physically-impaired
2	People who use wheelchairs (and crutches)
1	People with a physical disability
1	People with activity limitations
1	People with impaired mobility
1	People with mobility access needs
4	*People with mobility disabilities*
9	*People with mobility impairments*
1	People with mobility limitations
5	*People with physical disabilities*
3	People with reduced mobility
1	Person on wheelchair
1	Person with crutches
1	Persons with a motor disability
1	Persons with mobility disabilities
1	Persons with mobility impairments
2	Person/s with physical disabilities
3	Physically-disabled
1	Physically-disabled individuals
3	Physically-disabled people
1	Physically-disabled persons
1	Physically-disabled tourists
1	Respondents with motor disabilities
1	Those with mobility problems
1	Tourists who use a wheelchair
1	Tourists with a mobility limitation
2	Tourists with mobility disabilities
1	Tourists with physical disabilities
1	Travellers with impaired mobility
3	Travellers with mobility impairments
1	Travellers with mobility problems
1	Travellers with physical disabilities
1	Users with a reduced mobility
1	Visitors with mobility impairments
1	Visitors with restricted mobility
1	Wheel-chair bound person
13	*Wheelchair user/s*
1	Workers with physical disabilities

Multiple

n	Term
1	Differently disabled people
1	Participant with different abilities
2	People with acquired disabilities
1	People with different impairments
1	People with diverse disabilities
1	People with severe disabilities
1	Those with multiple disabilities
1	Tourists with a health limitation
1	Tourists with different disabilities
1	Travellers with acquired disabilities

Sensitivities

n	Term
1	Disabled people with asthma and allergic problems

Vision

n	Term
1	Adults with vision impairment
1	Blind guests
1	Blind interviewees
1	Blind participants
7	*Blind people*
2	Blind person
1	Blind respondents
1	Blind tourists
2	Blind travellers
1	Blind user
1	Blinded people
3	Guests with (a) visual impairment/s
1	Individuals with vision impairment
1	Individuals with vision problems
2	Individuals with visual impairment/s
1	Participants with vision impairment
1	People who are blind
1	People who have vision impairment
1	People who were visually-impaired
1	People with sight impairments
4	*People with vision impairment/s*
3	Person with vision impairment
2	Person/s with visual impairment
1	Respondents with visual disabilities
1	Sight-restricted interviewees
1	Someone with a sight restriction
3	Those with vision impairment
3	Tourists with vision impairment
2	Vision-impaired
1	Visitors with visual impairments
1	Visually-impaired consumers
1	Visually-impaired individuals
1	Visually impaired participants
2	Visually impaired people
2	Visually impaired person/s

Table 7. Terminology: tourism categorisation – type of tourism.

Type of tourism	
Able-bodied tourism	1
Accessible tourism	*41*
Accessible travel	4
Barrier-free tourism	4
Barrier-free travel	1
Disabled tourism	1
Disability tourism	4
Inclusive tourism	1
Inclusive travel	1
Tourism for all	2
Tourism for disabled people	1
Tourism for people with disabilities	*6*
Tourism for the disabled	1
Tourism for the elderly	1
Travel for people with special needs	1
Travel for the disabled	1

confirm that, by and large, there remains little attempt to explore what this use of language means in practice (Walmsley, 2004).

Reasoning for the language and practice of accessible tourism

The content analysis showed that 34 publications (or 28% of the total sample) provided <u>no</u> reasoning as to why scholars employed particular terminology, nor was any reference made to the importance of, or issues related to the discourses of language (see Table 9). Eighty-six publications (or 72% of the total sample) did offer some level of engagement in terms of their use of language. This involved anything from a few sentences or a paragraph simply mentioning language, to several paragraphs or an entire sub-section explaining the scholar's rationale behind their language employment, or exploring language discourses in-depth. Although the majority was found to engage with language, this certainly did not mean that their positioning was necessarily provided, nor any critical discussion around it provided.

Table 8. Terminology: tourism categorisation – tourism market.

Tourism market	
Access market	2
Accessible tourism market	*6*
Accessible tourism niche	1
Accessibility market	3
Accessibility-requiring market	1
Ageing travel market	1
Disabled customers market	1
Disabled market	1
Disabled persons market	1
Disabled tourism market	2
Disabled travellers market	2
Disability market	3
Disability tourism market	1
Disability travel market	1
Mature travel market	2
Older tourism market	1
Senior/s market	3
Senior market segment	1
Senior tourism/t market	3
Senior travel market	1

Table 9. Definitions, context and discourse.

	Definitions (academic)	Definitions (legislative)	Definitions (official)	Definitions (self-defined)	Context (cultural)	Context (geographic)	Context (legislative)	Discourse (models)	Discourse (language)
Number of publications	24	26	27	14	10	16	17	41	12
Percentage of total sub-sample	28%	30%	31%	16%	12%	19%	20%	48%	14%

From analysis of the eighty-six publications that offered some level of engagement with the language of disability and accessibility, four key themes inductively emerged, coded as *terminology*, *context*, *discourse* and *participant*. *Terminology* encompassed widely cited "academic", universally accepted "official" and country-specific "legislative" definitions. *Context* denoted "cultural", "geographic" and "legislative" circumstances. *Discourse* pertained to predominant "models of disability" – namely the medical and social models of disability – in addition to discourses surrounding the "language of disability". The final theme, *participant*, explored perspectives of the participants themselves.

The theme of *terminology* consisted largely of widely cited "academic", universally accepted "official" and country-specific "legislative" definitions, classifications and frameworks (Groschl, 2004) (see Table 9). Twenty-four publications (or 28% of the total sub-sample) provided "*academic*" terminology and associated conceptualisations that were the same as or similar to that of other widely cited scholars. Fourteen publications (or 16% of the total sub-sample) offered their own definitions (see Table 9). Notably, the majority included or engaged with Darcy and Dickson's (2009) well-recognised concept of "accessible tourism", which was acknowledged as being one of the first and only attempts at actually "defining the field". In acknowledging the whole-of-life focus of accessible tourism as a concept, potentially we can see the benefits emulated in practice by providing access for all (Michopoulou, Darcy, Ambrose, & Buhalis, 2015; Patterson, Darcy, & Monninghoff, 2012).

Twenty-seven publications (or 31% of the total sub-sample) included or engaged with definitions offered by official bodies (see Table 9), most frequently the definitions of the WHO and the United Nations Enable, followed by the United Nations and their Convention on the Rights of Persons with Disabilities (UNCRPD). Given the organisations' international status and workings, and their responsibility in setting "the norms and standards on health issues within the United Nations system", it could be suggested that the scholars have utilised these definitions because of this, that is, they are "suitable and recognisable to all audiences" (Kalargyrou & Volis, 2014, p. 432). However, Darcy (2010) disputes this rationality, arguing that its repercussion is that people with disabilities are then too "tightly confined to the definitional categories identified by the WHO" (p. 822). Other scholars within this sub-sample also debated the use of the WHO typologies, insisting them to be medically and individually inclined (Darcy & Buhalis, 2011b; Figueiredo, Eusebio, & Kastenholz, 2012), "based on a range of normative assumptions" that "create the dichotomy of normal/abnormal and, hence, are the origin for considering disability as other" (Darcy & Buhalis, 2011b, p. 25). This was an interesting finding considering almost all scholars within this sub-sample had either claimed explicitly or implicitly, their situation within, or support of, a social model approach to disability.

Several scholars gave reasoning for their use of terms in reference to the UNCRPD's definition of "persons with disabilities"; those with "long-term physical, mental, intellectual or sensory impairments which, in interaction with various attitudinal and environmental barriers, hinder their full and effective participation in society on an equal basis with others" (Smith, Amorim, & Umbelino, 2013, p. 8). The scholars who employed this definition, recognised it as being more socially grounded, arguing "that it is not the person's impairment that 'disables' someone from undertaking tourism experiences but the social, political and economic barriers that create the 'disabling' tourism environment" (Michopoulou et al., 2015, p. 182). Here, a person's impairment was neither a focus nor an issue,

rather the "dimensions of disability as an outcome of their access needs...identified as: mobility; vision; hearing; intellectual/cognitive/learning; mental health; sensitivities – including respiratory, food and chemical; other" (Darcy & Buhalis, 2011b, p. 5). The UNCRPD was framed on social model principles and a human-rights-based approach (Harpur, 2012a); hence, scholars citing this work frame their engagement around the social construction of enabling environments (Kayess & French, 2008; Lang, 2009). Interestingly, the frequency in citing of the UNCRPD definition was comparably less to that of the recurrence of the WHO definition/s, suggesting the on-going medicalised dominant worldview of conceptualising disability.

Twenty-six publications (or 30% of the total sub-sample) justified their use of terminology as aligned to their country's human rights legislation (see Table 9). A review of the terminology used in legislation revealed them to be unmistakeably medical. With reference to the Americans with Disabilities Act 1990, Stumbo, Wang, and Pegg (2011) warned of the consequences of emphasising disability to be that of a medical concern chiefly and of not understanding or placing emphasis upon the "fluidity of disability". Examples of more socially-supported legislation that scholars referred to included Canada's Canadian Employment Equity Act 1995 and New Zealand's Disability Strategy 2001. The Canadian Human Rights Commission 1995, for example, states that under the Canadian Employment Equity Act 1995, a "person with disability" is those "who have a long-term recurring physical, mental, sensory, psychiatric or learning impairment and who (a) consider themselves to be disadvantaged in employment by reason of that impairment, or (b) believe that an employer is likely to consider them to be disadvantaged in employment by reason of that impairment, and included persons who have been accommodated in their current job or workplace" (as cited in Groschl, 2004, p. 19). This definition recognises the socially constructed nature of disability, shifting the power of identification with one's impairment and the subsequent 'disabling' effect it may have to the individual themselves (Groschl, 2004). The New Zealand Disability Strategy 2001 also makes an important distinction between "impairment" and "disability", whereby "disability is the process that happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have" (as cited in Schitko & Simpson, 2012, p. 327).

As outlined in the WHO and World Bank's 2011 "*World Report on Disability*", "the underlying definitions of impairment and disability are contextual in the way they are operationalised across the globe" (as cited in Michopoulou et al., 2015, p. 182). A number of scholars attributed their choice in language, or alternatively discussed language in relation to the cultural (10 publications or 12% of the total sub-sample), geographic (16 publications or 19% of the total sub-sample) or legislative (17 publications or 20% of the total sub-sample) *contexts* of where they reside or engaged in their research (see Table 9). This finding confirmed the popular notion that disability is both constructed and impacted within a social context, during different times and in different places (Darcy & Buhalis, 2011a, 2011b; Dwyer & Darcy, 2011; Vila, Darcy, & Gonzalez, 2015; Zenko & Sardi, 2014). The content analysis revealed that some scholars disclosed the ways in which definitions and descriptions of disability could differ from one culture to another, as a result of varied perspectives of socio-cultural and economic factors; country-specific registration systems within a particular legislative domain; and circumstances related to the specific nature of impairment itself (Darcy & Buhalis, 2011b; Zajadacz, 2015).

In this respect, several scholars offered a footnote or a short statement conceding their specific choice in language as correlating to that of their particular cultural, geographic, legislative or political nomenclature. For example, Gillovic and McIntosh (2015) stated that "given the legislative terminology, context and geographic location of the researchers, being New Zealand, the term 'disabled people' was employed despite the researchers supporting the social model of disability; a model which generally prescribes the use of the term 'people with disabilities'" (p. 235). Comparably, Goodall, Pottinger, Dixon, and Russell (2004) also illustrated the United Kingdom's legislative milieu, citing their Judicial Studies Board and asserting that "person-first language is used throughout this article, but it should be noted that in the United Kingdom. 'disabled person' is preferred by the Disability Rights Commission because it reflects the social model (that the person is disabled by society)" (pp.

177–178). These two examples offer insight into what is perhaps one of the most well-known debates surrounding the language of disability; the distinct approaches offered geographically to describe the relationship between impairment and society, and the respective employment of adjective- or person-first terminology (Harpur, 2012). Despite Darcy and Ravinder (2012) suggesting that "people with disabilities" is the preferred descriptor within a Western context, the preceding examples illustrate issues of contention between the models and the socio-cultural contexts of where the scholars reside, therefore revealing international discrepancies in the context of communication. Not dissimilar, are acknowledgements of discordance in the dimensions of disability from one country to another. For example, the use of "intellectual disability" in New Zealand, "mental disabilities" in Turkey, "learning disability" in the United Kingdom and "mental retardation" in the United States of America (Bengisu & Balta, 2011).

Forty-one publications (or 48% of the total sub-sample) either included a statement situating the study within the social realm of disability, or engaged with the medical or social models of disability, acknowledging the ways in which tourism environments can be disabling by their nature, and that there is a necessity in working toward the creation of more enabling, inclusive and accessible environments (see Table 9). Within disability studies, the employment of language is significant in terms of one's selection and exercise of a particular approach to, or model of, disability (Harpur, 2012; Jaeger & Bowman, 2005). Specifically, the scholars in this sub-sample described the medical and social models of disability, offering their perspective and positioning in relation to these, generally situating themselves in support of the latter. For example, Darcy (2012) explained, "The social model informs this research by providing an understanding that socially constructed relationships are developed from three elements; (a) the lived experiences of TwD [tourists with disabilities], (b) identifying disability as the combination of impairment (intrapersonal) and socially constructed barriers (interpersonal, environment and attitudes) and (c) a conceptual clarification that transforms disabling environments to enabling environments through practices that remove structural and attitudinal barriers" (p. 3).

The move away from reference to the medical model of disability to the social model of disability has been a significant shift in the wider discourses surrounding the language of disability. Discussion around these discourses was featured in 12 publications (or 14% of the total sub-sample) (see Table 9). Such developments have generally engendered some dispute between the two models (Darcy & Buhalis, 23011b). Namely, the "promotion of 'person-first language' and rejection of purgative terms" (McDermott & Turk, 2014, p. 257), and particularly in regards to the use of "impairment" and "disability"; "adjective-first" or "person-first" language, that is, the use of "disabled people/persons" or "people/persons with disabilities", respectively, and "able-bodied" or "non-disabled" (Darcy & Buhalis, 2011a; Darcy & Ravinder, 2012). The latter of each option, generally-speaking, is argued to signify alignment with a social model approach to disability (Darcy & Ravinder, 2012). For instance, correctly distinguishing between the terms "impairment" and "disability" has become significant in conforming to a particular model of disability (Darcy & Buhalis, 2011a; Pagan, 2012; Winance, 2007). Within the medical disability discourse, definitions of impairment concentrate on the "loss", "lack of ability" or "tragedy" of an individual, whereas in the social disability discourse, "disability" is seen as a "social reality" firmly based on particular cultural, economic, political and social context. This is not to say that the term impairment has no place within a social approach; it is inherently connected to the notion of disability (Pearn, 2011). Therefore, "the defining element of the social model lies in the transformation of an impaired person to a disabled person as a product of the ways in which society is organised" (Darcy & Buhalis, 2011b, p. 27).

Also, there is disagreement between the uses of "adjective-first" or "person-first" terminology when ascribing to a particular model of disability. In disability studies, language, labelling and discourses have been resisted and reconfigured to promote positive connotations and express a person first perspective (Dunn & Andrews, 2015; Harpur, 2012). "The cultural habit of regarding the condition of the person, not the built environment or the social organisation of activities, as the source of the problem, is the most prevailing issue within the discussion of the social model of disability" (Darcy &

Buhalis, 2011b, p. 28). Some disability studies scholars demand that the utilisation of the social model of disability actually ratifies the use of "disabled people" (Darcy & Buhalis, 2011b), as this ordering suggests an individual's impairment is disabling as a result of society (and not the individual), therefore, producing disabled people (Clark & Marsh, 2002; Darcy & Ravinder, 2012). Jaeger and Bowman (2005), however, argue that this ordering of words emphasises the impairment and identifies the individual by this. Again, the employment of such terminology can be geographically contextual, where, in the United Kingdom, the descriptor of "disabled people" frames such attributes of disablement to society rather than the individual (Clark & Marsh, 2002). It is clear then, that language, meanings and discourses are never stable or fixed and are always in flux, open to challenge and re/new use.

Conversely, 'person-first' language "places emphasis on the person first and foremost, and the disability, whatever that may be, second. It does not separate the terms, only placing an order to their use" (Darcy & Ravinder, 2012, p. 209). In this way, linguistically, people are defined by their "humanity" in favour of their "attribution" with impairment, and disability becomes subsidiary to the individual (Harpur, 2012; Jaeger & Bowman, 2005). Shakespeare (2006) argues, however, that the expression "people with disabilities" may suggest that those who are disabled, possess something deficit, singular and personal to themselves, meaning they would, therefore, not be disabled by society. Again, the employment of such terminology can be geographically contextual, where in Australia and the United States of America, the use of "people with disabilities" is employed, defining people by their "humanity" rather than their attribute (Darcy, 2003). Thirty-one scholars employed the term "disabled people" in their publications, while 77 scholars employed the term "people with disabilities" in their publications. However, importantly, given the levels of inconsistency at large, this is not to say they did not also employ the term "people with disabilities" (see Table 3) or "disabled people", respectively (see Table 4).

Finally, twelve publications (or 14% of the total sub-sample) used language either prescribed or defined by their *participants*. As anticipated, the responses were varied, yet the common dimensions of the language used were generally in terms of some sort of restriction. In this view, "disability is seen as a product of bodily limitations, suggesting a view of disability as predominantly shaped by a medical model" (Nicolaisen, Blichfeldt, & Sonnenschein, 2012, p. 207).

Conclusion

This paper offered an original contribution in providing a first and critical examination of the language used in previous studies of accessible tourism to consider an agenda for social change. The paper addressed three research questions: what language has been used in "accessible tourism" scholarship; what reasoning do scholars offer, if at all, for their use of language; and, what are the implications of this language use on the discourse of "accessible tourism" and social change? The content analysis revealed that diversity exists amongst the varying terminologies adopted by scholars, and that terms are employed loosely, inconsistently and interchangeably, euphemistically with erroneous understandings and nuances. Most scholars do not appear to make a conscious effort to explain their underlying philosophical and linguistic position. Therefore, from both a language and representation perspective, the implications are that tourism scholars need to be cognisant of the heterogeneity of language to more fully engage with the dimensions of access, embodiment and enabling support, and to better socially respond to the needs of the diversity of this group. At the same time, there needs to be an explicit consideration of language as part of the contribution to this social construction and sustainability of enabling environments. Through this article, we hope to encourage tourism scholars to become more cognisant and critical about the use of their language and its impact for social change. We recommend as future research lines of research, to examine non-English languages and their cultural contexts, the legislation of those destinations and official bodies, stakeholder service provision and training, and importantly, the preferred terminology of

travellers with disabilities themselves, to enable positive change. To this end, we also suggest that this paper provides a good starting point for public consultation in the environment of people with disabilities.

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No potential conflict of interest was reported by the authors.

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