Power, competence and constructing disabling barriers: A discursive analysis of communications between professionals and a person with impairment

Lindsey Threlfall

Supervised by: Julia Robinson   April 2014

Power, competence and constructing disabling barriers: A discursive analysis of communications between professionals and a person with impairment

ABSTRACT

Previous research pertaining to impairment and disability has principally targeted the construction of disabling barriers through a multitude of means. However, unapparent and more ambiguous constructs have received insufficient recognition. This research aspires to contribute to such literature regarding the construction of disabling barriers and specifically provide insights into the discursive aspects of those constructions.

Fairclough's approach to critical discourse analysis (CDA) was adapted to identify specific discourses leading to the construction of disabling barriers, including power and competence. Three concepts characteristic of critical discursive psychology, and outlined by Reynolds and Wetherell, were utilised for the analysis of eight professional documents. The concepts included interpretative repertoires, ideological dilemmas and subject positions, and were used in line with the analysis of discursive constructions.

Particular attention was paid to the relationship between the researcher and person with impairment, whereby subjectivity was believed to enhance analysis.

A variety of discourses were interpreted from the data, underpinning the implications of power, competence and accessibility in relation to disabling barriers.

KEY WORDS:	DISABLING BARRIERS	INTERPRETATIVE REPERTOIRE	IDEOLOGICAL DILEMMA	SUBJECT POSITION	CDA

Background

The nature of this research coincides with discursive conventions utilised by the journal of Disability and Society. The journal exemplifies discourses that were maintained by the researcher during the entirety of this report in an attempt to deconstruct disabling barriers. Thus, this project refers to the person whose documents were analysed as 'person with impairment' throughout.

Disabling Barriers

If we are asked to think of a person with a disability, do we consider the ways in which a person is challenged by disabling societal barriers or do we immediately relate to their impairment? Most common is the latter, as Finkelstein (2004:18) advocated:

> ...the prevailing view that it is personal impairments that disable us is reinforced every day by the media, 'care' assessments, medical forms and so on.

In opposition, the social model of disability (Oliver, 1983) conjured the idea that impairment does not equal disability; rather, society has created barriers that disable a person with impairment. The wide implementation of Oliver's model in society has resulted in changes to media images, accessibility and the legal system.

Accordingly, the social model of disability served as motivation for this research and was appropriated to encourage further understanding of professional discursive relationships. Moreover, this research adopted the model to act as an ideological "tool to improve people's lives" (Oliver, 2013:1025) and in doing so, sought to acknowledge how beneficial changes could be made to the lives of people with impairment.

Although disability literature tends to advocate beliefs similar to those held by Oliver, barriers in education, employment and health systems withstand, though they have lessened. An illustration of such barriers was outlined in an interview with mothers who discussed the struggles faced in having a child with impairment (Goodley and Lawthom, 2006). The inaccessibility of support for their child was likened to a persistent battle against barriers. This inaccessibility was just one example of the hindrances society places upon the lives of people with impairment. This type of barrier can occur in various settings, yet focus should not reside solely within context. Goodley (2011:114) alleged:

> The impaired body is materialised through a multitude of disciplinary practices and institutional discourses [and] shares all of this shaping due to its consistent engagement with a whole plethora of disabling practices and discourses.

This research anticipated the reiteration of Goodley's notion that continuous involvement with institutional discourses may contribute to the construction of disability in professional documents. However, discourses that actively dismantled those barriers were not rendered worthless to this research.

Within this project, it was understood that the creation of disabling barriers does not rely upon any one medium. Thus, 'disabling barriers' was employed as an umbrella term that encompasses an abundance of contributing factors. The researcher's choice to focus particularly on discursive constructions of power was influenced by vast literary contributions. In contrast, it was the limited literary discussion concerning discursive constructions of competence, which led to the development of this idea as a second focal point.

Power

Research has often implied that involvement in diagnosis and treatment would empower people with impairment and place them "in control of how their needs are met" (Department of Health, 2000:online). It could be argued that regardless of mutuality, 'patients' would remain aware of power imbalances because they seek the advice of 'professionals'. Although this somewhat advocates power differentials, this research aimed to identify how they are further advocated by professional discourses.

There are endless ways of constructing power inequalities and choice of discourse contributes largely to those constructions. Discourses are the product of pre-existing linguistic resources and personal preferences, and interests in those resources (Parker, 2002). Available resources construct our world and inform our interpretative repertoires about disability. Fine and Asch (2010:9) stated, "When a disabled person faces problems, it is assumed that the impairment causes them"; thus, this available resource aids in the construction of impairment as the cause of disability. Hence, through those preferential discourses, misinformed interpretative repertoires are reciprocated.

Furthermore, the knowledge presented by professionals in their discourse influences power imbalances. For example, unexplained medical terms and jargon may exclude the 'patient'. Gillman (2004) proposed that by sharing their expertise, avoiding language that may exclude and sharing information about support, professionals could share power. Accordingly, the subject positions of 'professional' and 'patient' are influenced by the available repertoires by which we act appropriately (McKnight, 1981, cited in Abberley, 2004). Here, subject positions act as a barrier, rendering a person in need of help from a professional. Goodley and Lawthom (2006) suggested that where the professional assumes the role of solving the problem, a medicalised, and therefore depersonalised, approach to diagnosis and treatment is adopted. Similarly, people who identify as 'patients' prefer to defer to expert knowledge, commending their needs to the help of professionals.

This approach was disputed in Freudian psychoanalysis techniques, whereby the role of knowledgeable professionals and helpless patients were contested, by use of equal contribution. Smart (1985, cited in Proctor, 2002:50) described this technique as "confession". The concept of equal contribution attempted to eradicate the 'patient' role of someone seeking a medicalised solution; instead, involving the person in diagnosis and treatment to quash power inequalities. Although this technique was previously a success it has not been generalised within social systems, including various professional contexts. Thus, regardless of scope for improvement, the professional-patient differential remains.

Competence

Evidence of disabling barriers constructed by competence was scarce within previous literature, yet Goodley and Lawthom (2010:102) described "distributed competence" in terms of psychology within disability studies as "the extent to which competence is enabled or stifled through the networks of support one has in one's life".

People with impairment often seek advice from professional practices that act as an important network of support. Thus, access to additional aid is paramount (Schulz and Decker, 1985) in creating as many possible networks of support for people with impairment. Though additional support may vary depending upon specific requirements, examples include counselling, psychotherapy and disability organisations that focus on the involvement of people with impairment and disability (Manchester Disabled People's Access Group, 2014). By increasing those networks of support, professional systems could provide services that enable competence.

Alternatively, discourses can construct a potentially stifling or enabling environment for competence. This was studied by Bolt (2009:3), who analysed fictional texts and concluded that disability in fiction was often used metaphorically for a person "lacking" particular attributes. Here, a lack of attributes suggested an inability to achieve something successfully, therefore pertaining to incompetence.

Bolt's findings motivated this research to ponder the prominence of enabling or stifling discursive constructions of competence in professional documents, as opposed to fictional texts. A wider aim of this research was to expand the minimal literature relating to the discursive construction of competence and to amplify its significance in creating disabling barriers.

Rationale

As a British female aged twenty-two, the researcher's upbringing, beliefs and understandings have been influenced by relevant societal, environmental and political influences along the way. At the specific time of writing this report, political influences were poignant, playing a role in the decision to study discourse and disability. For example, a particularly relevant news article headlined:

> MPs say it is unacceptable that disabled people are waiting six months or more to find out if they are eligible for benefits (BBC, 2014:online).

Such recent occurrences inspired the researcher's interests and position.

Primarily, the researcher's best friend who has lived with physical impairment since birth motivated the specific nature of this project. Studying Psychology enlightened the researcher to think critically about their shared experiences. The researcher's friend had portrayed hospitals and assessment centres as incredibly daunting. Her reliance upon, and trust invested in, professionals was seemingly paramount to the power differentials encountered in the professional-patient relationship. Notably, 'common-sense' principles were used liberally, with little deliberation; the person with impairment was referred to as 'disabled' or a 'patient' within the medical systems that were consistently medicalised and depersonalised.

Subsequent reading of literature revealed that many others who consider the 'professional-patient' affair to be a disabling, power imbalanced, and often stifling affiliation, were attempting to enforce changes (Wright, 1983); further inspiring the content of this project.

Objectives

Fairclough's (2001) critical discourse analysis (CDA) technique was adapted in this research. To analyse eight professional documents, three characteristic concepts of CDA (Reynolds and Wetherell, 2003) were employed: subject positions, interpretative repertoires and ideological dilemmas. Each concept was used with the hope of increasing society's understanding of discursive constructions and their implications, particularly within professional documents. Respectively, this research focused on the construction of power, competency and other disabling barriers through the medium of discourse.

Constructs were selected and research questions were defined by developing the following ideas from previous literature:

- Venn (1984:72) suggested that people with impairment must out-perform those without impairment, jumping through bureaucratic hoops in order to prove themselves as 'able'. Building upon this idea, the research aimed to provide an answer to the following question: Which discourses of power do the documents draw upon?
- Bolt (2009:15) analysed a range of fictional data and established that people with impairment were portrayed as incompetent. In this research, non-fictional data was analysed to answer the following question in relation to Bolt's findings: How is the competency of the person with impairment constructed through discourse?
- The way that disabling barriers can be constructed via the use of language has been explored by Goodley (2011:114), who suggested that disability is a result of interactions with a "whole plethora of disabling practices and discourses". The following question relates to Goodley's proposition: How else, and to what extent, does the discourse construct disabling barriers?

Methodology

Design

This project utilised a qualitative case study design with the aim of providing information about a very specific and rare case. Though results cannot be generalised, the use of professional and often standardised documents means that others' experiences may be likened to those in this case study.

For analysis, Fairclough's (2001) critical discourse analysis (CDA) technique underpinned the use of three concepts characteristic of CDA: subject positions, interpretative repertoires and ideological dilemmas (Reynolds and Wetherell, 2003). This method was appropriated with the aim of identifying how the construction of

power, competence and other disabling barriers were manifested in professional documents belonging to a person with impairment.

Materials

The person with impairment and guardian completed relevant paperwork before the researcher received the documents for analysis (Appendix 2-5). The documents consisted of an appeal form, various letters from health and legal professionals, and a healthcare assessment.

Texts for Analysis

As this research used discourse analysis, participants were not required. The information required consisted of eight professional documents from various social systems. Documents were obtained from a friend of the researcher who was born with physical impairment.

The key below outlines the documents used for analysis, where each is assigned with a letter. Throughout the analysis, documents were referred to using their corresponding letters. These documents were chosen in particular because they provided a diverse range of information from numerous social systems, which allowed for a multiplicity of alternative discursive conventions to be analysed. The texts accurately represented the variety of professional documents that a person may encounter during their communication with various social systems. Documents were not included as an appendix due to their confidential nature.

Key

Texts for analysis

A- Appeal
B- Letter: Surgeon to Doctor
C- Disability Living Allowance Letter
D- Letter: Physiotherapist to Professional
E- Tribunal Service Decision Notice
F- Tribunal Service Letter of Request
G- Healthcare Professional Assessment
H- Disability Living Allowance Letter

Data Analysis Method

Foucault's notion of discourse involved language and language use (Willig, 2001) and focused on variability, function and construction. This research was concerned with the characteristic of construction: Specifically, the discursive construction of disabling barriers. For this reason, Foucault's idea partially underpinned the methodological guidelines prescribed by Fairclough (2001:229) in critical discourse analysis (CDA):

> [CDA] is critical in the sense that it aims to show non-obvious ways in which language is involved in social relations of power and domination, and in

ideology. It is a resource which can be used in combination with others for researching change in contemporary social life.

Consequently, three key concepts said to lie at the heart of critical discursive psychology (Edley, 2001) were appropriated.

Interpretative repertoires formed the first of the concepts, described by Reynolds and Wetherell (2003:496) as "...building blocks through which people develop accounts and versions of significant events and through which they perform social life." Particularly, they are the unspoken yet familiar rules and routines that form the social consensus belonging to a significant event. For example, when visiting a doctor's surgery we arrive as a patient with problems that only a professional can 'cure'. Inevitably, these rules and routines render us a specific role, which pertains to the second concept: Subject positions. Davies and Harre (1990) suggested that interaction hands us a position to speak from, in turn positioning others. However, discourse often proves highly variable, as Foucault (1980) suggested. Variability poses ideological dilemmas that occur because of conflicting, incompatible discourses. Hence, those ideological dilemmas formed the final concept. Various predicaments were exemplified by Billig et al (1988:35), such as the dilemma between "many hands make light work" and "too many cooks spoil the broth". Each of the three concepts constituted a solid methodological framework from which to consider discursive constructions of disabling barriers in professional documents.

Drew and Sorjonen (2006) extended Fairclough's notion of analysis further, suggesting that people orient toward their institutional identities. This refers to the regulations of social consensus that are available to us and allow us to construct ourselves by employment of subject positions. Thus, those repertoires and positions impose upon our choice of discourses and likely result in ideological dilemmas.

Though the social model of disability does not contribute to the methodological framework of this report, Oliver (2013) indicated that it could provide the basis upon which professionals ground their work. The Disabled People's Movement embraced the social model and as a result, changes in the law, media, public buildings and transport networks, were enforced (Finkelstein, 2007). Although many professionals embraced the social model in their own disciplines, "solutions offered to people [with impairment] are based on an individual model" (Oliver, 2013:1025). Thus, Oliver's model was utilised in this research with the aim of lessening disabling barriers within social systems by making changes to disabling professional discourses.

Ethical Considerations and Implications

This research project progressed through the university ethics procedure under the British Psychological Society (BPS) ethical guidelines (Appendix 1). All relevant paperwork regarding data collection was completed before the research commenced (Appendix 2-5).

One of the largest considerations for this study was the relationship between the person with impairment and the researcher, which placed the researcher in a position where utilising personal data could be an issue. In the code of ethics, this ethical issue appeared under the ethical standard of multiple relationships (BPS, 2009; APA, 2010). As the researcher assumed the role of a professional

psychologist, a professional, as well as a non-professional, relationship existed. The British Psychological Society (BPS) code of ethics and conduct (2009:online) states that:

> Psychologists should remain aware of the problems that may result from dual or multiple relationships.

These problems included, but were not limited to, the hindrance of objectivity, competence or effectiveness. However, the role of the researcher as a friend was not "reasonably expected to cause impairment or risk exploitation or harm" (APA 2010:online). Therefore, the relationship was considered ethically sound.

Most importantly, this report could receive criticism due to its subjective nature. Fox and Prilleltensky (1997) suggest that psychologists often ignore the way that their choices are affected by their moral, political and social stance. On the other hand, they suggest that:

> …these choices are never entirely objective or free from values, assumptions, and biases. By acknowledging how our own values and experiences affect us, we expose our work to a kind of scrutiny that more mainstream work avoids (1997:15).

Similarly, according to Hollway (1989:133), "subjectivity provides the basis for enriched social and psychological knowledge". Thus, subjectivity was employed as "information that should be taken into account" as opposed to an "obstacle" (Kidder and Fine, 1997:34) and was used reflexively as part of the rationale for this project.

Overall, these ideas led to the belief that embracing subjectivity may prove advantageous in various means. Firstly, the researcher already had the trust of her friend and could be sure that this was reciprocated. Additionally, the involvement of professionals encountered by the person with impairment was an occurrence with which the researcher was already familiar. Resultantly, the subject of this research was studied confidently while stringently enforcing criticism, understanding and respect.

Analysis and Discussion

This analysis exemplifies a critical discourse analysis technique outlined by Fairclough (2001). The analysis was conducted with reference to three key concepts that coincide with Fairclough's approach: Interpretative repertoires, ideological dilemmas and subject positions (Edley 2001; Reynolds and Wetherell, 2003).

With this in mind, the researcher aimed to identify the role that discourse has played in the construction of disabling barriers in professional documents. Three questions were used to assist the analysis: "Which discourses of power do the documents draw upon?"; "How is the competency of the person with impairment constructed through discourse?" and "How else, and to what extent, does the discourse construct disabling barriers?" Though the latter encompassed the preceding questions, it was an important aim of this research to acknowledge alternative discursive constructions of disabling barriers. Consequently, 'disabling barriers' was not defined as a singular construct in itself. Instead, the phrase became an umbrella term to encompass a multitude of concepts that contributed to their construction, some of which have received little recognition in previous discursive literature. Accordingly, this analysis

further evidenced the construction of disability through discourses of power and competence.

Often, the connection between discourses can become obscured (Schiffrin, 1990). Here, the documents used and the discourses within them bear a strong connection and it is necessary for the reader to understand those interrelations. Hence, a flowchart detailing the connectedness and the process of analysis can be found in Appendix 6.

Discourses of Expertise and Bureaucracy

From the outset, the assertion of power through knowledge was evident in the documents, a concept that has received countless acknowledgements in past literature (Foucault, 1980; Davis, 1993; Gillman, 2004). Document D[1] presented numerous medical terms used in reference to impairment; each term unexplained and, to an unfamiliar eye, difficult to understand. The person with impairment was evidently aware of the "Ilizarov surgery" she received and the "flexion contracture" related to this. Nevertheless, the medical nature of the terminology and a suggested unwillingness to share professional expertise potentially excluded the person with impairment. This immediately signified the power of the professional within the medical system. The power inequality resounding throughout document D satisfied the notion of the 'professional-patient' relationship; a familiar subject position recognised, but unscrutinised, by professionals and patients alike.

Likewise, document G utilised knowledge to exert power. Surprisingly, its representation of knowledge posed a contradiction; the completed form used slang words and unprofessional vocabulary such as "hopping". Specifically, it was important to consider that the professional was working within an oppressive social system where interpretative repertoires allow us to adhere to the rules of the professional-patient relationship. Here, the contradiction of those rules through the misuse of unprofessional discourse presents itself as an ideological dilemma. Oppressive discourse utilised within social systems requires the compliance of professionals, yet the disregard of professionalism and the corruption of power in document G led to an equally disabling outcome.

Notably, the professional assumed the position of decision maker; a position relied upon so often that it is integral to society's repertoires. In adhering to those repertoires, document B revealed a depersonalised approach to treatment, which further empowered the professional role: "my plan", "she will need to". Through the discursive exploitation of bureaucracy, the professional was conventionally positioned as the decision maker. Issuing plans and orders excluded the person with impairment and created an obstruction to collaboration and choice. As Shearer (1981:96) so deftly described it: "Often it is more a question of obeying the staff than discussing things with them." Seemingly, the primary function of document B was to exert power.

Unbelievably, the following question was asked in document A: "Tell us what their illnesses and disabilities are and how they are affected by them." Automatically,

---

[1] Documents were alphabetised and can be viewed in Methodology: Key.

society's repertoires regarding disability were reiterated by the assumption that people are subsequently affected by their impairment. This positioned the person with impairment as 'the helpless patient' and differentiated between those affected by illness and disability, and those unaffected. Thus, according to that repertoire, the person with impairment was constructed as disabled.

However, document A's question was suggestive of an ideological answer; if a person is affected by their impairment, they must be affected in a specific manner. Thus, such questions provide a discursive example of the bureaucratic hoops that powerful, professional systems insist people with impairment jump through, in order to receive support (McPherson, 1991).

Respectively, Document G asked: "What is their main disabling condition?" The indefinite focus on a 'condition' being disabling adhered to the existing definitions of disability as a physical or mental manifestation (Equality Act, 2010) utilised in society's repertoires, as opposed to those that define impairment and disability separately. This was discriminatory, defining and limiting as the person with impairment was positioned as 'disabled'. Sequentially, professional systems dictate the assumption that "an inability in one area must mean that the whole person is helpless" (Shearer, 1981:111), hereby contributing further to the construction of the impaired as powerless, disabled and incompetent.

In that assumption, the close interrelation between the construction of barriers through discursive exploitation of power and competence was evidenced (Appendix 6). Distinctively, the constant battle to affirm impairment to receive support was juxtaposed by the necessity for people with impairment to prove their ability (Venn, 1984) or competence to powerful social systems.

Bureaucratic and expert discourses embolden society to abide by, and reinforce, available repertoires alluding to the power-imbalanced 'professional-patient' relationship. Thus, the 'patient' should rightly expect professionalism in their pursuit of knowledge (Goodley and Lawthom, 2006). However, should an equal partnership surface, it may prove advantageous to remember that "the people who are 'professionals' are the people who have been there themselves" (Shearer, 1981:121).

By sharing expertise, professionals could permit participation in discussions and enhance the understanding of the person with impairment (Pound and Hewitt, 2004). Mirroring the therapeutic notion of equal contribution (Rawlings and Carter, 1977) through an alteration of discursive conventions could lead to a rebalance of power. Likewise, this could abrogate the typical interpretative repertoire of a helpless patient seeking a professional cure, as power would no longer remain marginalised within the realms of professionals.

Resultantly, the researcher was led to believe that incorporating elements of feminist therapy could lead to the depletion of power inequalities and nurture equality. Similar to the beliefs held by this research and the social model of disability, feminist therapists have often argued that many problems arise because of disempowering social forces (Rowan, 2001). Thus, adopting a technique used in feminist therapies whereby the professional and patient work as equals, could prove beneficial. For instance, the patient could recognise social powers that construct disabling barriers

and enhance their own authority in exchange for their removal (Worell and Remer, 2002).

Negative and Stifling Discourses

Pointedly, pessimistic attitudes and the treatment of impairment as a problem were exemplified in the documents by the use of negative and stifling discourses, alluding to the concept of competence.

Negative attitudes were constructed through discourse placing a certain assumption that impairment is unfavourable and restrictive. Discourses within the documents were wholly negative, limiting and presumptuous. Negative wording such as "lack of" (B) and "functional restrictions" (G) implied that the person with impairment could not be fully competent, a construct defined by the oppressive systems in control of such documents. As Shearer (1981:123) described:

> [Professionals] have unfortunately defined limits for various disability categories. As professionals, we need to help our patients define their expectations upward.

By defining limits for 'patients', social systems immediately stifle a person's ability and further progression.

Likewise, the following phrase from document A was extremely restrictive: "Are you able to walk?" On the surface, this may seem like an adequate question. With further analysis, it was evident that only an answer of 'Yes' would construe a person with impairment as competent. Had the person with impairment replied alternatively, they immediately assume the role of a person with an inability to walk. This stifling discourse represents the repertoires that are often regurgitated without thought or criticism and are exemplified in common assumptions that focus on a lack of ability and "accentuate imperfections" (Camilleri, 1999:848). This illustrates how society's repertoires draw upon, and reflect, the notions portrayed by discourses within professional systems. Subsequently, incompetence was prescribed for the person with impairment, disregarding their ability.

The copious amount of proof that the person provided in order to evidence their impairment was astounding. The request for "medical evidence" was a seemingly recurring event, visualised in documents E, F and H. This represented the constant battle that people with impairment face in order to receive the support that they need (Goodley and Lawthom, 2006). Additionally, the damaging effect that those battles could have upon a person with impairment, remained undetermined. The prerequisite of proving your impairment to professionals whose judgements are based on standardised tests and questions was a seemingly oppressive encounter, one certain to render a person with impairment as incompetent. Unfortunately, choices in such matters are often revoked, as Shearer (1981:113) unearthed:

> Nothing happens unless we keep on and on making a nuisance of ourselves.

Thus, the adherence to repertoires of evidence was clearly no choice of the person with impairment; rather, this was a choice between assuming the position of competent or incompetent, which would reflect in the support received. Society should not impose the revocation of choice upon a person, especially when

concerning his or her own needs (Danforth and Rhodes, 1997). Evidently, society's concern was with justice for people without impairment, by ensuring that those with impairment are as 'unable' as they claim to be.

Analysis led to the understanding that pessimism within the documents portrayed impairment as ultimately problematic, by the use of negative discourses. Here, the relationship between the constructions of disabling barriers within the documents was epitomised. Appendix 6 illustrates the affiliation between pessimism and the construction of impairment as a problem.

Societal repertoires regarding impairment as disabling were represented and the use of stifling discourses was invoked. In document A, a standardised appeal form aimed at people with varying impairment, gave the following options to answer a question regarding walking ability: "normal", "adequate", "poor" or "extremely poor". Externally, the use of negative words was striking; the word "normal" suggested that lesser ability would be deemed abnormal. Thus, the researcher was provoked to believe that a differing ability level would be viewed as problematic, locating the person with impairment as 'incompetent'.

Moreover, in assuming that walking ability would be affected, the discourse reduced the person into the positioning of a "tragic victim" of their impairment (Oliver, 2013:1024). This assumption reiterated society's repertoire that impairment causes people to suffer, as opposed to environments causally linking impairment and disability. Thus, document A recognised people with impairment as less competent than those with "normal" ability.

In contrast, the researcher found the informative and collaborative nature of document C to be enlightening. Its discourses differed to other documents within the analysis and conflicted available repertoires of impairment and disability. Resultantly, an ideological dilemma was posed between repertoires regarding people with impairment as 'unable', versus less available repertoires regarding people with impairment as 'able'.

Specifically, document C did not refer to the person with impairment as having a disability, nor did it address their impairment as problematic. Indeed, by sharing information and encouraging collaboration, the discursive conventions followed by other professional systems were broken down. Importantly, this letter represented discourses utilised in relation to law, and lacking in medical nature. Seemingly, discourses in medical documents were restrictive due to their understanding of disability as a physical disposition (Jones, 1996). However, professionals are confined to discursive conventions dictated by oppressive social systems within which they function. Those boundaries limit opportunities to enable people with impairment within such social systems, resulting in the rarity of enabling documents.

Essentially, the documents defined competence by the use of pessimistic attitudes and the portrayal of impairment as problematic. Social systems possess the power to change documents and the discursive constructions of disabling barriers within them. One way to do this would be to consider documents from a humanist perspective, a prominent approach that pays particular attention to human potential (Dillon, 2013). Adopting this stance within professional documents could encourage patients to view themselves as a whole person, as opposed to a person with impairment or disability. By considering the person with impairment as a whole person rather than a set of

symptoms or problematic impairments, their lives could be enabled and society's current repertoires of impairment as problematic could be challenged.

Likewise, positive psychology is an ever-emerging topic that provides an effective basis for enabling a person by rivalling negativity and targeting positive aspects (Seligman and Csikszentmihalyi, 2000). If social systems were to invest a focus on positive features within their documents, professional discourses could aid people with impairment in fulfilling their abilities and personal goals and professional-patient relationships could become an enabling experience.

Deterministic Discourses and Accessibility

Comprehensively, the experience of communicating with professional systems demonstrates a barrier in itself; numerous forms to fill in, various professional assessments and countless interactions with a whole plethora of practices can build a wall between the person with impairment and the expert (Eng et al. 1998). Arguably, services have altered considerably since the 1970's when the work of Oliver, Finkelstein, Hunt and many more was most profound (see: Union of the Physically Impaired Against Segregation, 1974 and The Social Model of Disability, 1983). However, what seemed most prominent in the documents was that the services were not alone in forging disabling barriers. In fact, it seemed that the process of gaining access to those services via a multitude of rigorous means constructed those obstacles.

This seemingly materialised through deterministic discourses dictated by social systems, who understand impairment as a purely physical manifestation. Likewise, accessibility of support was based upon subjective understandings of pain. Those subjective discourses ignored individual differences and determined a universal experience of malaise. Thus, accessibility became a prominent discursive construction that contributed to the assembly of disabling barriers in professional documents. Nonetheless, assuming that those barriers were constructed via the direct use of discourse would be a slightly misled inference. What was found upon analysis of the documents was that often it was what was left unsaid, which spawned confinements.

Firstly, accessibility to alternative support proved to be an abundant issue. Predominantly, the professional discourses in document G chose to concern physical therapies. While physical therapy may prove helpful for many, therapies that were undisclosed suggested inaccessibility to alternative support. Additionally, concentration on one aspect of rehabilitation may "distort the process" (Shearer, 1981:111). People with impairment may not require alternative support yet the ignorance within the social system was displayed in the assumption that physical therapy should be the sole offering. Not only does this affect a person's access to potentially useful resources, it also reinforces society's repertoire of impairment as a physically disabling concern exacting physical assistance.

Perhaps the most outstanding of all was the barrier to accessing support, whereby the person must be in "pain for at least 6 months". Firstly, this relates to competence, suggesting that until the boundaries are satisfied, a person is competent enough to

cope without support[2]. Moreover, as a subjective feeling, pain tolerance differs for every person. The document attempted to standardise pain and in doing so, created a barrier. Secondly, in specifying a length of time that pain should be experienced for, the document limited accessibility and rendered the person with impairment as unworthy of support unless this time was satisfied. Hunt (1966:98) related to this type of convention as "subtly corrupting", where the choice of discourse does not directly disable a person. However, the insertion of time restraints, and the subjective decision of what constitutes pain, places social systems in a position of inaccessibility, renders the person with impairment as undeserving of support and ultimately constructs a disabling barrier to accessing support.

Fundamentally, accessibility was restricted through discourses that reiterated society's repertoires of impairment and disability based on their medical model definition. Those repertoires focus predominantly on physical and generalisable manifestations of impairment and pain within the individual (Swain et al, 2003). Though it is understandable that medical documents pertain to medical conditions, their ignorance toward equally affecting aspects regards disability as a product of impairment. If the social model definitions of impairment and disability were utilised within professional social systems, the creation of barriers to accessing support may lessen. For example, in understanding that disability is a result of social constructions, powerful systems could utilise documents to offer non-physical support and nullify the concept of disability as merely a physical outcome of impairment.

Summary

Potentially, this report could catalyse developments in professional documents, where professionals would relate to a person with impairment as equal, as opposed to regarding them as 'disabled' or 'patients'. Ultimately, this could mean that people with impairments are included and empowered, rather than disabled by their means of adaptation and their 'patient' status, which is assembled via discursive constructions.

An additional overarching aim of this research was to contribute to literature suggesting that definitions of disability:

> ...often start from medical understandings of disability, which may clash with contemporary understandings of disability as being environmentally based (Grövnik, 2007:2).

The findings of this research encourage future definitions of impairment and disability to coincide with the social model of disability, where social, environmental and political factors that render a person with impairment as disabled are highlighted, as opposed to the current definitions that consider disability as a product of impairment (Equality Act, 2010).

Perhaps one of the most important quotes from previous literature was the following, from Macfarlane (1996:7):

Illness and impairment do not equal disability, nor do they cause it.

---

[2] See Appendix 6 for a detailed illustration of the documents' connectedness.

Whilst illness and impairment can exist as single entities, disability cannot exist without illness and impairment. However to eradicate the term 'disability' would be unwise; in fact, it would prove particularly ignorant. Although we are aware of the barriers that cause impairments to be fared as disabilities, our ignorance in acknowledging those barriers could be remodelled as a disabling factor in itself. Instead, entrusting the knowledge that people with, and without impairment, have and using it to convert society into a better-educated environment, could lead to an improved understanding of what impairment really entails.

Reflexive Analysis

In line with Willig's (2008) notion, I have chosen to separate my reflexive analysis into two sections: Personal and epistemological reflexivity.

Personal Reflexivity

Throughout this report, subjectivity was utilised reflexively as an important tool, allowing for the exploration of my role in influencing and informing the research (Nightingale and Cromby, 1999). Researcher subjectivity was hugely influential throughout; the familiarity of the person with impairment influenced the outlook of this project and encouraged a realistic perspective of disabling barriers. Those subjectivities were drawn from my personal understanding of experiences of the person with impairment.

This report contributes to a wealth of literature regarding disability, society and discourse. Specifically, it contributes to the construction of disabling barriers in professional documents from a discursive perspective: one that has received minimal attention in the past. Though I approached this research with a pre-meditated idea of disability, I have found that discursive constructions of disabling barriers often appear in a multitude of ways. Respectively, I am now conscious of my discursive contributions to constructing aspects of society.

Epistemological Reflexivity

Assumptions made about discursive constructions of disabling barriers were informed by previous research, the documents and knowledge about the person with impairment. The research aims and title were based on those assumptions, which defined and limited the findings of the research. Though the research was limited to discourse, the study of discourse within the broad concept of disabling barriers meant that there was scope for variety within the analysis.

The use of a case study method meant that information about a very rare case could be identified. Though the documents regarded a specific impairment, the writing conventions were characteristic of particular social systems suggesting that the report may have widely applicable implications. Thus, though perspectives were subjective, that subjectivity was influenced by the first-hand knowledge of a person's experience of living with impairment in a society where powerful systems dictate rules.

Due to those dictations, it was expected that documents would illustrate the discursive constructions of disabling constraints; this belief related to themes

throughout disability literature and the experiences of the person with impairment. Those expectations were mostly correct, although dependent on which social system was involved. For example, the law system resolved those disabling discursive constructions and instead, the person with impairment was constructed equally, regardless of impairment or disability.

Throughout, personal reflexivity has aided my understanding of how my position in society has shaped the research and how the research has affected me as a researcher. Likewise, epistemological reflexivity has assisted my understanding of how the research was fashioned by my assumptions and the implications of those assumptions.

References

Abberley, P. (2004) 'A critique of professional support and intervention.' *In* Swain, J., French, S., Barnes, C. and Thomas, C. (eds.) *Disabling Barriers – Enabling Environments.* 2nd ed., London: Sage, pp. 239-241.

American Psychological Association. (2010) *Ethical Principles of Psychologists and Code of Conduct: Including 2010 Amendments.* [Online] [Accessed on 19th November 2013] http://www.apa.org/ethics/code/index.aspx?item=6

BBC News. (2014) 'Disabled benefit delays unacceptable, say MPs.' *BBC News: UK Politics.*[Online] 18th March. [Accessed on 27 March 2014] http://www.bbc.co.uk/news/uk-politics-26615853

Billig, M., Condor, S., Edwards, D., Gane, M., Middleton, D. and Radley, A. (1988) *Ideological Dilemmas: A Social Psychology of Everyday Thinking.* London: Sage.

Bolt, D. (2009). 'Introduction: Literary disability studies in the UK.' *Journal of Cultural and Literary Disability Studies,* 3(3), pp. 1-4.

British Psychological Society. (2009). *The Code of Ethics and Conduct.* [Online] [Accessed on 28th November 2013] http://www.bps.org.uk/sites/default/ files/documents/code_of_ethic_and_conduct.pdf

Camilleri, J. M. (1999) 'Disability: A personal odyssey'. *Disability and Society,* 14 (6), pp. 845-853.

Danforth, S. and Rhodes, W. C. (1997) 'Deconstructing Disability: A Philosophy for Inclusion'. *Remedial and Special Education,* 18 (6), pp.357-366.

Davies, B. and Harré, R. (1990) 'Positioning: The Discursive Production of Selves'. *Journal for the Theory of Social Behaviour,* 20(1), pp. 43–63.

Davis, K. (1993) 'The Crafting of Good Clients.' *In* Swain, J., Finkelstein, V., French, S. and Oliver, M. (eds.) *Disabling Barriers – Enabling Environments.* London: Sage, pp. 197-200.

Department of Health. (2000) *A Quality Strategy for Social Care.* London: Department of Health.

Dillon, J. J. (2013) 'Using Socrates to Teach Psychology: A Humanistic Approach to Psychology'. *Journal of Humanistic Psychology,* 53 (3), pp. 362-385.

Drew, P. and Sorjonen, M. (2006). 'Dialogue in Institutional Interactions.' *In* Van Dijk, T. A. (ed.) *Discourse Studies: A Multidisciplinary Introduction.* London: Sage, pp. 191-216.

Edley, N. (2001). 'Analysing Masculinity: Interpretative Repertoires, Ideological Dilemmas and Subject Positions.' *In* Yates, S., Taylor, S. and Wetherell, M. (eds.) *Discourse as Data: A Guide for Analysis.* London: Sage, pp. 189-228.

Eng, T. R., Maxfield, A., Patrick, K., Deering, M. J., Ratzan, S. C. and Gustafson, D. H. (1998) 'Access to Health Information and Support: A Public Highway or a Private Road?' *The Journal of the American Medical Association,* 280 (15), pp. 1371-1375.

Fairclough, N (2001). *Language and Power.* 2nd ed., Essex: Pearson.

Finkelstein, V. (2004) 'Representing disability.' *In* Swain, J., French, S., Barnes, C. and Thomas, C. (eds.) *Disabling Barriers – Enabling Environments.* 2nd ed., London: Sage, p. 18.

Finkelstein, V. (2007) 'The 'Social Model of Disability' and the Disability Movement'. *Manchester, GMCDP,* pp. 1-15.

Foucault, M. (1969) *The Archaeology of Knowledge.* London: Routledge.

Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings 1972-1977.* Brighton: Harvester Press.

Fox, D. and Prilleltensky, I. (1997) *Critical Psychology: An Introduction.* London: Sage.

Gillman, M. (2004). 'Diagnosis and Assessment in the Lives of Disabled People: Creating Potentials/Limiting Possibilities?' *In* Swain, J., French, S., Barnes, C. and Thomas, C. (eds.) *Disabling Barriers: Enabling Environments.* 2nd ed., London: Sage, p. 256.

Goodley, D. (2011) *Disability Studies: An Interdisciplinary Introduction.* London: Sage.

Goodley, D. and Lawthom, R. (2006). *Disability and Psychology: Critical introductions and reflections.* Basingstoke: Palgrave Macmillan.

Goodley, D. and Lawthom, R. (2010). 'Disability and Empire: making sense of disability in changing economic times.' *International Journal of Inclusive Education,* 15(5), pp. 101-115.

Gov.uk. (2010) *Definition of disability under the Equality Act 2010.* [Online] [Accessed on 28th November 2013] https://www.gov.uk/definition-of-disability-under-equality-act-2010

Grövnik, L. (2007) *Definitions of Disability in Social Sciences.* Ph.D. Uppsala University.

Hollway, W. (1989) *Subjectivity and Method in Psychology: Gender, Meaning and Science.* London: Sage.

Jones, S. R. (1996) 'Toward inclusive theory: Disability as social construction'. *NASPA Journal,* 33(1), pp. 347-354.

Kidder, L. H. and Fine, M. (1997) 'Qualitative Inquiry in Psychology: A Radical Tradition.' *In* Fox, D. and Prilleltensky, I. (eds.) *Critical Psychology: An Introduction.* London: Sage, pp. 34-50.

Manchester Disabled People's Access Group. (2014) *MDPAG Services and Activities.* [Online] [Accessed on 12 March 2014] http://www.mdpag.org.uk/what.htm

McPherson, C. (1991) 'Violence against Women with Disabilities: Out of Sight, Out of Mind'. *Canadian Woman Studies,* 11(4), pp. 49-50.

Nightingale, D. J. and Cromby, J. (1999) *Social constructionist psychology: A critical analysis of theory and practice.* Buckingham: Open University Press.

Nunkoosing, K. and Haydon-Laurelut, M. (2011) 'Intellectual disabilities, challenging behaviour and referral texts: a critical discourse analysis.' *Disability and Society,* 26(4), pp. 405-417.

Oliver, M. (1983) *Social Work with Disabled People.* Basingstoke: Macmillan.

Oliver, M (2013) 'The social model of disability: Thirty years on.' *Disability and Society,* 28(7), pp. 1024-1026.

Parker, I. (1994) 'Reflexive research and the grounding of analysis: Social psychology and the psy-complex.' *Journal of Community and Applied Social Psychology*, 4(4), pp. 128-131; 238-252.

Parker, I. (2002) *Critical Discursive Psychology.* Basingstoke: Palgrave Macmillan.

Rawlings, E. I. and Carter, D. K. (1977) *Psychotherapy for women: Treatment toward equality.* Oxford: Charles. C. Thomas.

Reynolds, J. and Wetherell, M. (2003) 'The Discursive Climate of Singleness: The Consequences for Women's Negotiation of a Single Identity.' *Feminism and Psychology*, 13(4), pp.489-510.

Rogers, C. R. (1957) 'The necessary and sufficient conditions for therapeutic personality change.' *Journal of Consulting Psychology,* 21, pp.95-103. (Issue number missing).

Rowan, J. (2001) *A guide to humanistic psychology.* California: Association for Humanistic Psychology.

Schiffrin, D. (1990) 'The language of discourse: Connections inside and out'. *Text and Talk,* 10(1),pp. 97-100.

Schulz, R. and Decker, S. (1985) 'Long-term adjustment to physical disability: The role of social support, perceived control, and self-blame'. *Journal of Personality and Social Psychology,* 48(5), pp. 1162-1172.

Seligman, M. E. P. and Csikszentmihalyi, M. (2000) 'Positive psychology: An introduction'. *American Psychologist,* 55(1), pp. 5-14.

Smart, B. (1985) *Michel Foucault.* Chichester: Ellis Horwood.

Swain, J., French, S. and Cameron, C. (2003) *Controversial Issues in a Disabling Society.* Buckingham: OU Press.

The National Archives (1998) *Data Protection Act 1998.* [Online] [Accessed on 19th November 2013] http://www.legislation.gov.uk/ukpga/1998/29/contents

Venn, C. (1984) 'The subject of psychology.' *In* Henriques, J., Hollway, W., Urwin, C., Venn, C. and Walkerdine, V. (eds.) *Changing the Subject: Psychology, Social Regulation and Subjectivity.* London: Methuen, pp. 115-147.

Willig, C (2001) *Introducing Qualitative Research in Psychology: Adventures in theory and method.* Berkshire: Open University Press.

Wright, B. A. (1983) *Physical disability – a psychosocial approach.* 2nd ed., New York: Harper-Collins Publishers.

Worell, J. and Remer, P. (2002) *Feminist Perspectives in Therapy: Empowering Diverse Women.* New Jersey: John Wiley & Sons, Inc.