Disability and care: a discourse analysis

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This study explores ‘care’ and ‘disability’, as they are some of the most value-laden and flexible terms in society, with a multitude of definitions and interpretations. Socio-psychoanalytical concepts (Richards, 2008) were useful for illustrating the notion that narratives and discourses regarding disability are spoken in terms of ‘us’ and ‘them’. Eagleton however (1983: 127), argues that one cannot be viewed without the other. This is why it is important to view both sides under their appropriate contexts, as disability can be outlined in day-to-day life under a number of discourses such as gender and power. In light of this, the method of unstructured interviews proved useful when collecting the stories and perceptions of three male participants and three male participants. All participants varied in terms of the level of care they provided or required. Emerging arguments or binaries were analysed through discourse analysis. The research found that there were three main issues regarding disability and care: Formal and informal care, the possession or loss of control, and resulting outlooks towards disability. These main issues contained further issues regarding discourses around gender, age and power. Limitations of the study included mainly organisational issues, and further research could be developed in greater detail with the use of Critical Discourse Analysis (Fairclough & Wodak, 1997).
Introduction

Disability is applicable to a multitude of topics within psychology; however, disability in the context of its discourse, specifically social and cultural viewpoints appear to give a more dominant presence.

Socio-psychoanalytic concepts comfortably integrate with the notion of disability in general as it elaborates upon how basic human instincts and functions apply to social systems and cultures. Within the study, this approach drapes over disability in general, and is apparent in each sub-context in terms of ‘splitting’. In Freudian and Kleinian terms, splitting is a basic instinct that polarizes ideas and populations in order to perpetuate cultural roots, in that there is good or bad, abled or disabled, advantaged and disadvantaged, rather than a continuum or graduation of ability. Richards (2008) builds upon this by stating that the ‘representation of people as other (not like the norm) comes at a cost to their humanity.’ She furthers her statement by explaining that because of this, people who are ill or disabled in care can submit to a style of writing that simplifies their experiences and ‘objectifies them’. This poses similarities to ‘othering’, which means reducing a complex being to an object. People living with disabilities or are regularly “reduced to the status of malfunctioning bodies” and viewed as ‘lacking capacity to put forward their point of view’ (McDougall, 2006, p. 395). More specifically, they are characterised in such a way that they are crushed into a medicalised narrative. Within research, people living with disabilities are objects and not as agents of study. This idea is common in modern systems and institutions of care were support is standardised and split into discrete sections. These sections are labelled under the disguise of ‘caring for’ people (Kelly, 2011) and people are often shaped into them rather than forms of care being shaped around the individual. Socio-psychoanalytical concepts are useful for illustrating these concepts and the general notion that narratives and discourses regarding disability are spoken in terms of ‘us’ and ‘them’. This over-arching theory of conflict merges into other perspectives, and its place within disability and care depends upon their rooted contexts. This is why binaries and arguments in discourse are beneficial for bringing other perspectives into light. Eagleton, (1983: 127) brings ideas of splitting and othering into a more post-modern state, as he argues that the implied meaning of a sign is understood only because of the ‘relationship between two or more signifiers (words or symbols)’. This means that one polar opposite cannot be discussed without the context of the other. This suggests the possibility of harmony, as two symbols can be complementary. However, more often than not, the relationship involves power because one symbol actively oppresses the other. This moves on to the specific meanings words.

In terms of ‘disability’ and ‘care’ there is a spectrum of meaning depending upon the culture or context. For example, American studies often focus upon aesthetics of disability, with discourses regarding aesthetics and interaction (Garland-Thomson, 2009) and narratives in Western literature (Snyder and Mitchell, 2000, 2006) being popular. However, in Britain there is a strong bond between meanings of disability within contexts of structure and power. With the National Health Service (NHS) being a dominant branch of British society, the research around care and disability often lies within quantifiable trends or discrete inabilities. Kelly (2011) argues against this, and suggests that whilst care applies to objective frameworks, it can also apply to
the exploration of daily relationships between clients and support workers. This is the area of focus within the study as disabled people and their carers create complex relationships that base more upon emotion than just physical aid, economics and power. This is where discourses form, and where the heart of this study lies.

Kress (1985, p. 7) describes discourse as a ‘set of possible statements about a given area’, and this gives structure to the manner in which a particular topic, object or process is to be talked about. This illustrates the freedom of direction and the complexities of discourse, and this is useful for uncovering where ideas of disability and care lie. However, to be more specific, discourse seems more of a process, were interpretations from speech and text relate to their social context (Howarth, 2007). Without the process of discourse, there is no chance for meaning to grow, and each individual entity or event stands alone, lacking relation to meaningful categories (Österlind, 2011). This is why discourse is more comparable to a journey, as discourses and narratives are advantageously subjective, and in turn, deeply embedded into other subject branches. Theories of discourse rightly focus upon webs of interaction and creative significance, unlike scientific methods, which create frameworks of manageability and control (Potter 1996).

The process itself generally involves a deconstruction of the text in order to highlight oppositions, contradictions and hegemony (Laclau and Mouffe, 2001). This links in to the use of binaries, power and polarizing ideas within discourse analysis as previously discussed. Particularly in discourse, the justification of the use of binaries relates to Foucault’s ideas of discourse and power. Foucault challenged the concept of knowledge of being objective, and instead suggested that knowledge closely relates to power and he ventured into what he termed the ‘knowledge/power’ connection through use of discourse. Cheek (2003) stated that Foucault successfully applied this nexus to many topics including healthcare. Foucault (1980) argues that partnerships in healthcare are mapped by discourse, meaning that they are produced by the relationship between ‘power/knowledge’ that gives supporters of particular discourses the ability to speak with authority and deny other ways of viewing aspects of reality. In other words, systems of care regularly contain users of a discourse that creates power through knowledge. This shows that discursive frameworks within a social structure often create binaries, and these binaries are often regarding power, control and professionalism.

Disability research based upon qualitative methods such as discourse analysis is critical for advancing the argument that disability is a social construction with oppressive and controlling attachments. Goffman (1963) created the potential to view disability as a social role in a manipulative framework. He explained that the wider society created disability by allowing barriers to form whether economic, relational or architectural. The ethics of discourse challenge these barriers, as they allow the oppressed to voice their opinions and views. Discourse and disability studies are a fundamental way of exploring how discourses and forms of communication relate to the oppressive meanings and labels behind disability within societal structures. Increasing studies around these topics would make positive change more likely to occur within soft systems, healthcare systems, institutions of care, and society as a whole.
Grue (2011) stated that whilst disability is becoming a significant topic of academic review, discourse studies remain a rarity; compared with similar branches of minority, disadvantaged or marginalised identities. Topics such as race, gender and age directly relate to discourse analysis in past research, and it appears that disability is merely a factor within them. Grue continues to say that ‘the identity markers of class, gender, race and ethnicity are being supplemented by that of disability.’ Discussion of disability needs to be dominant, and topics such as class and gender should become only a part of it. Ideas of disability and care need to shift from being an example of marginalisation to an independent topic. This is why the key objective of this study is to gain rich and detailed accounts laced with an abundance of emotional themes, discourses and narratives. This in order to discover the ways people perceive power in the world of care. This study also wishes to explore the accounts of those who have a personal knowledge of care and emphasize the importance of their stories of care. This in turn intends to support the idea that discourse analysis is suited to disability studies as much as they are with other marginalised identities such as class or gender.

The overall aim of the study is to a) explore the perceptions of participants regarding their feelings and attitudes in day-to-day life as a carer/ disabled person, b) explore the arguments that occur within the accounts of those who provide or receive care and c) use emerging arguments from accounts to form topics of discourse within the topic of disability and care. Further aims of the study are to d) to gain a rich understanding of the arguments, feelings and emotions felt by participants within the appropriate context and e) apply the arguments raised to other relating discourses.

**Method**

Upon judgement of background literature and knowledge, qualitative methods seemed most appropriate. Recruitment of participants happened under the method of snowball sampling, and the findings were collected through unstructured interviews. Following this, the application of discourse analysis unpicked the transcripts and developed key binaries and areas of discussion relating to care and disability.

Access to two private places of care (a day care centre with sheltered living, and a residential home) provided an effective starting point, and they were both accessible through an identified gatekeeper. The gatekeeper was additionally willing to become a participant within the study, and act as a primary starting point for the snowball sampling of further participants (Biernacki & Waldorf, 1981). The initial contact with participants occurred before the interviews took place, with potential participants receiving a letter (see Appendix 1) and an attached participant information pack, which contained all of the details needed in order to give full informed consent to the study. The pack included information sheets, interview schedule topics and consent forms (see Appendices 2, 3 and 4 respectively). The information sheets and consent form included and explained all of the relevant ethical considerations within the study, so participants were able to give full informed consent. The information pack contained all of the intentions and processes of the study, so the participant information sheet did not withhold any information or contain any points of deception. The pack also consistently reminded participants that they have the right to withdraw
in the event that someone has misinterpreted the study, if they do not wish to take further participation, or if they wish to withdraw particular sections of information. Participants were also be reminded that, particularly with unstructured interviews, the process of recalling memories and stories may cause emotional upset, but would be no more than what is expressed or experienced in everyday life. No participant was at risk of physical or mental harm. Carter et al. (2008) regarding their study upon interviews, found that the interview experience could 'be upsetting', and many participants 'needed a break during at least one interview because of this.' The packs considered this, and participants were reminded that if they wished to pause or discontinue the interview, they had the right to do so. The above points were reiterated before and after interviews, and the completed Ethics Check Form (ECF) and Application for Ethics Approval Form (AEAF) also reflected the included considerations (see Appendix 5 and 6). The letters and packs circulated through the post and the gathering of consent forms often occurred prior the interview. After this, the personal distribution of additional packs increased as a participant network developed. Kim and Fox (2006) suggested that the value of snowball sampling lies in its ability to 'uncover subjugated or ignored knowledge of lay persons' views of social life' by allowing both participants and researchers to share their views within the context of their own concerns. This originally justified the choice of snowball sampling, and in practise, the method provided the potential for new and unconsidered branches of discussion to emerge. For example, one of the participants who possess a job in a charity-based service recommended the inclusion of a family member who worked within the NHS. Overall, six participants deemed to be sufficient and substantial since the amount of information gathered from each participant was so rich, and the study has no intention to gather a quantitative or generalised opinion. Overall, the participants consisted of three women and three men, ranging from ages nineteen to sixty-four years of age. Of these participants, two provided care only and two received care only. The remaining two both provided and received care.

On completion of recruitment and participant consent, the process of unstructured interviews began. Participants retained their interview topic guide included in the participant packs (see appendix 3). This was in order to revive memories and give a sense of what the interview would hope to uncover. Ramos (1989) explained that unstructured interviews are shared experiences, in which participants feel comfortable in telling their stories. From this, the idea of unstructured interviews seemed appropriate as it provided participants with the opportunity to convey their true thoughts, feelings and opinions of care and disability. More quantitative methods such as closed questionnaires would provide a strong illustration of general views, but unstructured interviews allowed the exchange of contextual views and explanations. The collection of recordings made from each unstructured interview gave way to the chosen process of discourse analysis.

Although researchers have labelled conversational analysis as a starting point, the focus is empirically upon the 'content of talk, its subject matter and with its social rather than linguistic organisation.' (Edwards and Potter, 1992, p. 28). The focus upon content, context and social standpoint was vital, and its applications needed to be consistent throughout the analysis. More critical and conversational aspects of discourse analysis were considered, but upon reflection, it seemed that the inclusion
of different discourses and different levels of interpretation (Alexander et al., 1987; Fairclough & Wodak, 1997) regarding different issues was too complex. Additionally, the focus upon text and syntax would dominate over the abstract issues within the findings, compared to Foucauldian processes that embrace wider aspects. It appears that a wider approach of discourse analysis based on social philosophies and cultural analysis is needed (Foucault, 1971). Foucault's work has been applied to psychology, sociology (Henriques et al, 1984) and cultural studies, (Coward, 1984) which has tried to show that practises, institutions and the individual human can be understood as a product through the workings of a set of discourses. Hollway’s (1989) study presented examples of this, as it attempted to show how an issue (decisions upon avoiding contraception in intercourse) could be constructed through a number of different discourses: a traditional Christian discourse, a social change discourse, and a feminist discourse. This particular study set out to emulate this process by identifying emerging arguments and binaries regarding disability and care, and elaborate upon them through a number of different contexts.

This will be carried out by firstly using a set of transcription symbols, more specifically a simplified version of the symbol key developed by Gail Jefferson (1984/2002). Content of the interview transcripts (see Appendix 7), can include things such as short pauses, long pauses emphasis created upon specific words (Riemann and Schutze, 1987, p. 348). This was effective, as it helped to tease or lift out specific topics of discussion that the participant found either particularly important or hard to express (silences or pauses regarded as equally important to words). Following this, the studying of completed transcriptions (see appendix 7 and 8) helped identify developing arguments and binaries regarding the discussed topics (Wetherell & Potter, 1998). Subtle issues were also found, and these were appropriately placed within their linking arguments. The process continued by applying the identified arguments to their most appropriate or applicable forms of discourse (feminist discourse, cultural discourse, family discourse).

Analysis

Analysis identified three main issues: The possession or loss of control, formal informal care and resulting outlooks towards disability. The issue of formal and informal care raised the further question of whether a person naturally cares or learns to care. Control was branched into two ideas in that control for the disabled person was relating to himself or herself, and control for the carer was in relation to physical provisions. Finally, the issue of outlook and attitudes towards disability was largely shaped by age, gender and humour.

“It is like a bomb going off in your life really, that totally throws everything out in different directions” (4:266-267)

Vs.

“It’s good to feel independent and not in a stubborn way but to try and, you know keep control, it is control.” (4:374-375)
This argument of control and dealing with disability is strongly linked to Foucault and his ideas surrounding empowerment, and care and the self. Michel Foucault’s idea of the ‘care of the self’ challenges ‘whether ill people can be empowered by telling their own stories in the attempt to reclaim their own experiences from the medical appropriation of illness’ (Frank, 1998). Regardless of whether they were in control or not, it seems that the talk of control within the transcripts is empowering in itself. On numerous occasions, there is mention of losing and gaining control, and this seems to be more cathartic than matter-of-fact. So, the ideas around control in discourses of power regard admittance to one’s self. Frank (1998) continued to talk of Foucault’s work, and suggested that to adopt a certain ethic as one’s own is to construct oneself as a kind of subject, becoming ‘the principle of [one’s] own subjection’. When the participants speak of control it is often about themselves, and at times, it seems that they are telling the story to the researcher and themselves. Helga demonstrates this when talking of her independence.

Well, I’ve never been one to feel sorry for myself, so maybe it’s my downfall as well, erm, it’s good for me to not feel sorry for myself and it’s good to feel independent, and not in a stubborn way but to try and, you know keep control, it is control... ‘we feel sorry for you’, can’t have that, can’t have people feeling sorry for me, ‘cause it won’t help me. It will not help. (4:372-378)

However, sometimes talk of control and power is not totally directed towards the self, but directed towards the interaction between the self and physical aids. There seems to be a process of gaining control over the walking stick or wheelchair, which is acting as a physical representation or metaphor for their disability. Mrs S stated:

Two years I never went out the door, erm, because didn’t want to use a wheelchair you know, I didn’t want to give in to that, then all of a sudden I thought “if I don’t use this wheelchair I’ll never go out the door again”, so we got a wheelchair.

Helga also went through the similar process; from seeing physical aids as oppressive to empowering.

When I had to use erm, the walking stick that’s not relying on somebody else as much... because it’s hard to cope with in feeling like oh you’ve got this thing that you don’t want.. Erm, but you’ve got to also partly give in to it knowing it’s gonna help you.

The other side of this is when those who provide care feel the loss or gain of control. This is almost always about environmental constraints and the prevention of care. Dolly explained that under the provision of care, control is gained when requirements are met and routines are solid.

... the most important thing with people with Alzheimer’s is routine... everything has to be the same every day!... breakfast has to be at the same time, lunch has to be at the same time, toilet needs have to be attended to as the same time everyday... (1:100-103)

Situations were ‘uncontrollable’ when they felt that they could not fulfil their duties.
Blackley applied great importance to control, and insisted that control needs to be kept in order for his care to be effective. (6:70-72)

Erm I spend three quarters of an hour to an hour every Sunday morning putting the pills up for the week... and then, erm... come the following Sunday I can say “you didn’t take such and such a pill”.

“...when it comes to professional carers they are a waste of space”

(6:711-712)

Vs.

“... We might look as if we don’t care but we do care” (1:552-553)

This binary largely focuses upon the discourses developed around formal and informal care, relating to issues around the provisions of support by professionals and family members. This binary is most applicable towards socio-psychoanalytic contexts, as it gives a strong sense of ‘us’ and ‘them’.

Supportive care for those with disabling conditions is gradually shifting from institutional settings to the ‘community’ or home setting (Aronson & Neysmith, 1996), and this is where family members are in control to offer the main source of care. Gilmour (2002) argued that “nursing and medical discourses shape care and family caregivers’ knowledge is excluded” (p. 551). Inger, Andershed and Ternestedt (2009) argue against Gilmour’s statement of institutional power, and describe it as an ‘unfortunate polarisation’. Nonetheless, the knowledge of informal caregivers is still fundamental. In Helga’s discourses, she elaborated upon this by saying:

...It still falls within your immediate family to try and keep that structure, that framework, keep all trying to move as best you can (4:58-60).

However, options of care may be restricted to members of the population with disabling conditions (Allen & Ciambrone, 2003) as social segregation is common amongst those with disability. The disability itself often acts as an obstacle, ‘splitting’ networks of friendship and family (Eggers & Zatz, 1998). Helga’s discourse mirrors this when she stated that:

It does stop you standing round talking with people or, erm, I have very little contact with friends because I stopped, started dropping out of going to physically do things with them (4:362-364).

Subsequently, this is when informal caregiving becomes unavailable, and individuals may choose to seek or resort to formal or professional caregiving (Allen & Ciambrone, 2003). Sometimes this is the case in elderly people with disabling conditions. After an established career in nursing and residential care, Dolly supported this by stating that:

...a lot of people who actually came to care, a lot of them didn’t have families... there were people who lived alone at home... nobody to actually care for them in their own home, so they couldn’t look after themselves...
However, when comparing the collected discourses around formal and informal care, the reliance upon formal care appears when family is present but unreliable. First, the concept of ‘burden’ upon family as a threshold for informal care (Cahill et al., 2009) is identified. This was apparent in Helga’s discourse, as she explained that:

…they’re concerned with making things as best they can to help you, but they’re emotionally attached, and it really hurts them to see you in that situation…” (4:178-179).

Continuing from this, Mrs S and her discourse around family burden focuses upon caring for her mother when she says:

You would you’d think, “oh not again I don’t want to do this again”… you want it to be someone else’s turn! (5:383-385).

Second, it is apparent in the discourses of Mr Bean, that some family members completely disregard another’s disabilities. Other negative emotions can come from family members as well as burden. In their study regarding the discourses of daughters caring for their dying parents, Read and Wuest (2007) found that the negative emotions experienced by the daughters included ‘helplessness and feelings of anxiety, sadness, hope, uncertainty, guilt, anger, frustration, despair, bitterness, and loneliness.’ This is demonstrated when Mr Bean talks of a disabled father and his abusive daughter, stating that the daughter is “totally oblivious” to his needs.

…but he did need help because he struggled getting up the stairs, you know it wasn’t any fault of his own, erm, but his daughter didn’t want any disabled equipment in the house at all… his daughter’s been escorted off the premises for assaulting him… because he was starting to get on her nerves because he needed help (3:437 443).

Finally, the negative emotions experienced by carers can overshadow the disabled person. Mr Bean told a story of trying to complete an assessment for an ill woman with her aggressive sister.

I went into this lady who’s just been diagnosed with cancer, but… she was quite a, calm lady to be honest with you after being told some, you know bad news like that, but she had a sister with her [coughs] and her sister was really, she wasn’t calm, she was a bit aggressive, I’m trying to do the assessment for this lady and her sister kept on interrupting every question trying to answer for her sister, not letting the sister talk for herself, basically. (3:154-160)

This illustrated how negative emotion within the family causes imbalances of power. However, Mr Bean also explained that he was stressed due to his workload and that he was under pressure. Stories like this not only describe events, they also represent a particular perspective or attitude of the person in that event. (Bochner, Ellis, & Tillmann-Healy, 1997). So, the sisters concern may have been misinterpreted as fury due to Mr Bean feeling stressed, showing that formal carers also have thresholds.
The idea of thresholds in informal and formal care leads on to the included binary of those who are “born to do it” and those who “see it as just money at the end of the month” (1:490). Bob explained in summary that:

You’ve got to think of it as just another job, but also at the same time you can’t think it’s just another job [laughs] it’s really hard to explain (2:271-271).

Based on his study concerning the caring systems of the elderly, Litwak (1985, cited in Aberg et al., 2004) determined that informal networks are most effective regarding tasks that do not require training or technical knowledge. Additionally, because informal helpers are motivated by internalised commitment rather than economic incentive, they are more effective at providing emotional support than formal systems. This creates the assumption that informal carers have a natural predisposition to care, and formal carers are paid to practise knowledge and skills of care. This may be due to ‘othering’ acting as a coping mechanism for staff. An example of this is when Bob states:

I was employed to help people do activities and if you get too involved you start getting emotionally attached to these people who, not saying they don’t deserve it… (2:101-102).

Although, Dolly suggests that professional carers do attach emotion to their users, and the idea of ‘carrying on’ is not othering in this particular case. ‘Carrying on’ seems to refer to being strong for others.

It says that like, nurses don’t mourn for the residents that they look after, but they do, a lot of them do. When we’re nursing people for years, and then they suddenly pass away, you do feel it, you really feel it. But you’ve got to carry on because there’s somebody else tomorrow that needs that same care, you know, we’re not all hard and uncaring (1:595-563).

Mr Bean also stressed his feeling towards situations where he had to see the disabled person as an ‘other.’

I had an assessment the other day were I’m, basically discussing the person I’m assessing in the same room, but with her daughter, so I had to ask all the daughter, the daughter all the questions and the assessment through her daughter because her mum had dementia, you know late stage dementia. Erm, that’s, that can be awkward, because I feel ignorant, that I’m not actually talking to the person that I’m assessing. (3:235-240)

“A lot of them would slope off to their rooms” (1:232-233)

Vs.

“Some people have a great outlook on life with this disability” (3:64)

This argument relates to outlooks and attitudes towards living with a disability. It appears that some people radiate feelings of depression, embarrassment and stubbornness, and others adopt feelings of optimism, positivity and acceptance.
Discourses of gender, age and humour all fit into this issue. Although Grue (2011) views disability as a supplement to gender, the results argue that gender is only an influence upon attitudes of disability.

Both age and gender differences are adorned upon the rules that govern contemporary societies. Moreover, they also affect each other. In other words, age is being gendered (Russell, 2007) and gender is ageing. This is constructing new ideas around gender and age, particularly in the issue of care. Feminist discourses were unexpectedly absent, as the participants themselves did not seem to fit into typical gendered roles. However when they talk of providing care for others, there is a focus upon men and control. Emslie and Hunt (2009) explained that ‘human health has been conceptualised using the (white, middle-class) male as the norm (the ‘universal man’).’ Many feminist studies have highlighted that this model ignores women, but in this particular case, it does not seem like ignorance. Men have become the subject of care because they resist to it and amuse themselves, whereas woman take advantage of available care and support each other. Mr Bean illustrated this when talking about his assessments.

Classic case, I went to… a bloke the other day he’s suffering from pulmonary… fibrosis I think. Erm, he’s struggling to breathe… once they start saying that they struggle to get up the stairs the first question I ask, “have you got facilities downstairs?”… erm, so if he takes too long going up the stairs and he’s desperate to use the toilet he can have accidents, and he admitted it, he said “yes, I have had a few accidents” so I offered him a commode, I said “would you like me to get you a commode for downstairs? just put it in a private room or a little cupboard or something like that were you can just use the commode if you don’t think you’re gonna make it” and he, the f- he just went “No, I do not want a commode, I am not using one of them!”… and it’s basically embarrassment and stubbornness. (3:417-429)

He also mentioned how women are often overly optimistic, taking control of care and the people who provide it without realising, to the point where it slows the process down.

People we do assess, especially the old, old, old people, especially the women, they like start talking to you and telling you stories, and then that sort of like deflects from the whole, it makes them relax obviously, I mean it helps me to relax sometimes having a laugh and a joke about it.. But also you want to stay professional and you don’t want it to go on too long… (3:304-308)

This is where attitudes and gender link with age. Gilliard and Higgs (2011) argued that recently, the positions of age, illness and disability have become ‘coherent social and cultural locations capable of acting as sites of agency and social argument.’ Regardless of whether they bring up esteem or difficulty, these statuses still leave space for individual agency, which can support personal identities and lifestyles. Helga outlined her identity when she spoke of using a walking stick.

Started off with loan of a wheelchair, erm physiotherapy and activity which involved learning to try and learn how to walk as best I could, erm, walking stick, erm… which I found I had to use for a while and then on and off for a
Mrs S took this further, and gave the attitude that age is expected in older people, and undeserving in youth.

Now we live in this area here that we are, especially built for aged stroke disabled persons, erm… there’s one that’s more ill than I am [laughs].. It’s another lady down there that’s also eighty something, and she’s bed ridden… but all the others are you know, quite fit and healthy… and they say to me “you don’t even know you’re born yet! You’re still a child” you know, one of the ladies has a daughter the same ages as me [laughs, then coughs] you know, it’s really quite frustrating. (5:724-730)

However, the use of humour turns this from quite a serious view into a light-hearted joke. This leads on to the use of humour when presenting attitudes towards disability and care. laughter." Kant (1942) studied humour, disability and illness, in the hope of better understanding the phenomenon of ‘inappropriate laughter’. However, he found that his participants spoke of laughter as a way of relieving tension and a way of reacting to the futility of struggling. Participants clearly differentiated their laughter from the feelings of unease associated with laughter. Kant concluded that humour for these individuals was not inappropriate, but ‘the appropriate reaction to a unique situation’ (Kant, 1942, p. 402).

…people able to laugh, that erm, after having a breast removed or something and going “well there’s nothing there now” you know “what about getting a tattoo of a fried egg?” or something like that you know that was like, but people found, it was calming as well, and it stopped it for a little while while being so serious, ’cause like life goes on and you’re trying to, and some ways it’s not big effort to find the humour. (4:303-308)

So it seems that humour also links to discourses of control. Humour in this case relates to hierarchies and power in relationships, and it useful for portraying attitudes. It has been found that humour is a means through which dominant relationships can be deconstructed and destabilised by oppressed individuals (Cardena & Littlewood, 2006). Helga demonstrates this when telling a story of her and a friend who was unaware of the extent of her disabilities.

I said “I just got to say to you, every time I see you I’m in the car” I said “or I’ve been leaning somewhere or something like that” she’s like you know, said “you’re like laughing and saying like about being you know as if I’m a lazy thing you know” look at her going “It’s a lovely day get a bit of fresh air, walk” so I said “the thing is” I said “I have a lot of pain, and I have trouble getting round” and he reaction was, “well I don’t care” [laughs] and it was really funny, it was really funny, “what are you telling me for?” and it was we were just laughing about it (4: 420-427)

This shows that Helga used humour as a way to break down relationships that
create tension, and appreciated when humour was reciprocated.

**Conclusion, Limitations and Further Research**

Overall, discourse analysis was effective for highlighting the dominant presence of control and power in disability. It was also useful for showing how more subtle topics such as attitude and humour can lead to forms of power. Adopting Foucauldian (1980) theories is the most likely cause of this, as well as taking the views of Richards (2008) and Goffman (1963). General limitations of the study are those often related to qualitative studies. The results are not generalizable, and the interpretations are subjective, so alternative ideas will form from the same transcripts (Powers, 2001). Personally, however, it seems that the most apparent limitation was the organisational structuring of the findings. Discourse theory analysis involves many links, twists, turns, circles and counter-arguments, and making sense of it all proved difficult. However, the complex nature of disability requires it, so the results were set in the most straightforward way without fear of losing contexts or meaning.

Numerous bodies of research can grow from this. First, it would be interesting to view ideas of disability and care through Critical Discourse Analysis. This study would provide an effective foundation for this method, and the findings would possibly benefit from the complex structure of Critical Discourse Analysis. Furthermore, an additional topic of mind and body emerged within the findings, but was not strong enough to constitute its own segment. This topic would work effectively in a fresh study regarding disability and discourse. **Reflexivity**

This work was very important to me, as disability is present within my networks of family and friends, and this is why I invested so much effort. When reflecting upon the chosen theory, I believe that this presence of power and strong, and I often experience the situations were disability and power collide. This is why discourse and theories of Foucault (1980) are influence me, as they let the opinions of those living with disability speak for themselves, in the way that they choose to.

Ethically, I became very aware of how participants felt when they spoke to me. One participant cried, and I questioned how that would affect me after completion of the study in my everyday life. However, I was reassured when the participant told me that it was good for them to let their feelings out. Overall, I don’t see the study as something for me. I feel that for the participants, it was a way of letting go and they felt as though they were being heard.

**References**


