The Social Construction of Disability in Occupational Therapy: An Examination of Muriel Driver Lectureships (1975-2009)

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Rehabilitation Sciences Institute
University of Toronto

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2015

Abstract

Disability is a core concept in rehabilitation sciences, and specifically in occupational therapy. Critical disability theory challenges the ways that disability is understood, and disability scholars have challenged rehabilitation professionals to reconsider how they conceptualize disability. The way that disability is given meaning is central to the profession of occupational therapy because it can influence client-therapist interactions, treatment plans and interventions, research agendas, services offered, and the development of policy. In my research, I address the need to examine how disability has been given meaning in occupational therapy. I adopt an overarching critical theoretical approach informed by social constructionism to examine the meaning of disability in the profession of occupational therapy. The objectives of the research include examining: a) how disability is presented in occupational therapy literature; b) what this tells us about the ideological, political, and theoretical underpinnings of disability; and c) what the dominant discourses of disability are in occupational therapy literature. I draw on methods developed by Fairclough to conduct a critical discourse analysis of highly influential Canadian occupational therapy texts (Muriel Driver Memorial Lectureships). The analysis is presented in two parts, discussing: (1) how disability has been broadly defined or described in the texts through written language and visual images; and (2) the existential meaning of disability in the texts. The
implications of text and dominant discursive practices related to disability on the professional practices of occupational therapy are discussed. Critical examination of how disability is conceptualized in occupational therapy allows for the consideration of alternative views of disability, which are likely to influence future occupational therapy theory, practice, and knowledge.
Acknowledgments

First and foremost, I would like to thank my supervisor and program advisory committee, Dr. Michael Iwama, Dr. Rebecca Renwick, and Dr. Tanya Titchkosky. Dr. Michael Iwama, my supervisor and Sensei—if it weren’t for our first meeting over coffee, I would not have pursued doctoral studies. Thank you for inspiring me to continue to question the ‘status quo’ in the spirit of continuous improvement and elevation of our profession, occupational therapy. And thank you for your kind, generous, and supportive approach. Dr. Rebecca Renwick has not only provided me with the ‘space’ to complete my doctoral studies, but she has also challenged me to think critically about core concepts in occupational therapy. Thank you for your support and guidance through the years. I am also ever grateful to Dr. Tanya Titchkosky, who introduced me to the field of critical disability studies at a moment in time when I was questioning the very notion of disability in occupational therapy. Not only have you supported and guided me through the complexity of textual analysis, you have also acted as a mentor to me.

Many other people have also played important roles in my doctoral journey. I would like to express my gratitude to Dr. Karen Whalley Hammell, who has generously provided both formal and informal mentorship throughout the years. Your work continues to inspire me, and my dedicated study time has always started with select readings from what I have come to refer to as ‘The Yellow Textbook’ (*Perspectives on Disability & Rehabilitation: Contesting Assumptions, Challenging Practices*).

Previous doctoral students advised me that the journey to completing a PhD is sometimes lonely. I am grateful to my family, loved ones, friends, and colleagues, who have given me just the right amount of space, encouragement, and support. Whether by holding my hand, pushing me forward, slowing me down, or simply listening to my research ideas, you have been with me every step of the way (even when we’ve been miles apart). You have also been patient with me, and for that I am grateful. I could not have gotten to this point without you. Thank you.

This work has also been shaped by endless conversations in the ‘Culture Lab’ with Rona Macdonald, a fellow doctoral student whose important insights have helped to shape my research. I am grateful for having had the opportunity to share lab space with you. Thank you for our conversations and for sharing your wisdom with me.
Lastly, this work was inspired by experiences that I had while working clinically as an occupational therapist. I owe this work to the many children and families who allowed me the honour of being part of their lives as an occupational therapist.

My research has been supported by the Social Sciences and Humanities Research Council of Canada, the Ontario Neurotrauma Foundation, and the University of Toronto Peterborough K.M. Hunter Scholarship.
# Table of Contents

Acknowledgments......................................................................................................................... iv  
Table of Contents.......................................................................................................................... vi  
List of Tables ..................................................................................................................................... ix  
List of Figures ................................................................................................................................. x  
List of Appendices ............................................................................................................................ xi  
Chapter 1 Research Paradigm and Research Question ................................................................. 1  
1 Organization of Thesis ............................................................................................................... 2  
2 History, Biomedicine, and Occupational Therapy ....................................................................... 3  
3 Models and Paradigms of Disability ............................................................................................ 7  
  3.1 Medical or individual model....................................................................................................... 7  
  3.2 Economic model ......................................................................................................................... 8  
  3.3 Functional-limitation paradigm ................................................................................................. 8  
  3.4 Social model............................................................................................................................... 8  
4 Research Paradigm ....................................................................................................................... 9  
  4.1 Situating the research ............................................................................................................... 10  
5 Research Question and Objectives ............................................................................................. 11  
6 Philosophical Framework ........................................................................................................... 12  
  6.1 Epistemology .......................................................................................................................... 12  
  6.2 Social constructionism ............................................................................................................. 13  
Chapter 2 Methods ........................................................................................................................ 16  
1 Critical Discourse Analysis .......................................................................................................... 16  
  1.1 Data selection ......................................................................................................................... 19  
  1.2 Design .................................................................................................................................... 20  
  1.3 Criteria for inclusion of texts ................................................................................................. 20
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4 Data analysis</td>
<td>22</td>
</tr>
<tr>
<td>1.4.1 Text analysis (description)</td>
<td>23</td>
</tr>
<tr>
<td>1.4.2 Processing analysis (interpretation)</td>
<td>25</td>
</tr>
<tr>
<td>1.4.3 Social analysis (explanation)</td>
<td>26</td>
</tr>
<tr>
<td>1.5 Limitations</td>
<td>26</td>
</tr>
<tr>
<td>1.6 Role of the researcher</td>
<td>27</td>
</tr>
<tr>
<td>2 Ethics</td>
<td>28</td>
</tr>
<tr>
<td>Chapter 3 What Is Disability?</td>
<td>29</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>29</td>
</tr>
<tr>
<td>2 The Language Struggle…‘Disability Etiquette’</td>
<td>29</td>
</tr>
<tr>
<td>2.1 Representations of social actors</td>
<td>30</td>
</tr>
<tr>
<td>3 Disability as a Problem…of Dysfunction</td>
<td>33</td>
</tr>
<tr>
<td>3.1 Textual analysis (description)</td>
<td>33</td>
</tr>
<tr>
<td>4 Occupational Therapy’s Role in Disability</td>
<td>36</td>
</tr>
<tr>
<td>4.1 Internal relations</td>
<td>39</td>
</tr>
<tr>
<td>5 Larger Social Context/Explanation</td>
<td>41</td>
</tr>
<tr>
<td>5.1 Interpretation and explanation</td>
<td>42</td>
</tr>
<tr>
<td>6 Summary of Chapter</td>
<td>45</td>
</tr>
<tr>
<td>Chapter 4 What Is the Meaning of Disability?</td>
<td>46</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>46</td>
</tr>
<tr>
<td>2 Cause and Effect</td>
<td>46</td>
</tr>
<tr>
<td>2.1 Causal relations</td>
<td>47</td>
</tr>
<tr>
<td>3 External Relations</td>
<td>49</td>
</tr>
<tr>
<td>3.1 Disability, health, and happiness</td>
<td>49</td>
</tr>
<tr>
<td>3.2 Disability, occupation, flow, and quality of life</td>
<td>51</td>
</tr>
<tr>
<td>3.2.1 Occupation</td>
<td>51</td>
</tr>
</tbody>
</table>
3.2.2 Flow ...................................................................................................................... 52
3.2.3 Quality of life ........................................................................................................ 52
3.2.4 Intersection between occupation, flow, quality of life, and disability .......... 53
3.3 Value assumptions .................................................................................................. 54
  3.3.1 Disability as a life with limits ............................................................................. 54
  3.3.2 Disability as a life with possibilities ................................................................. 58
4 Larger Social Context/Explanation .......................................................................... 60
5 Summary of Chapter ................................................................................................ 64
Chapter 5 Professional Practices of Occupational Therapy ..................................... 65
  1 Introduction ............................................................................................................. 65
  2 ‘Positioning’ of the Profession .............................................................................. 67
  3 Challenge to the Profession .................................................................................... 68
  4 How Do Constructions of Disability Serve the Profession? .................................. 69
  5 How Do Constructions of Disability Impede the Advancement of the Profession? .... 71
  6 Implications for Occupational Therapy ............................................................... 72
  7 Future Directions .................................................................................................... 73
  8 Summary of Chapter ............................................................................................... 73
Afterword ..................................................................................................................... 75
References ..................................................................................................................... 77
Appendix 1. Muriel Driver Memorial Lectureships (1975-2009) ....................... 89
Appendix 2. Data Analysis Sheet .............................................................................. 92
Appendix 3. Preliminary Data Analysis Patterns ..................................................... 97
Appendix 4. Three Dimensional Analysis ................................................................. 112
List of Tables

Table 1. Data Selection
List of Figures

Figure 1. Three Dimensional View of Discourse and Discourse Analysis

Figure 2. Speaking About Disability

Figure 3. The ‘Problem’ Called Disability

Figure 4. Relations of Collocation

Figure 5. Disability: Cause or Effect?

Figure 6. Schematic of Logical Implications: Disability/Illness

Figure 7. Schematic of Logical Implications: Disability/Happiness

Figure 8. Schematic of Logical Implications: Disability/Flow

Figure 9. Schematic of Logical Implications: Flow/Quality of Life

Figure 10. Disability as Life with Limits

Figure 11. Schematic of Logical Implications: Disability/Sub-Optimal Living

Figure 12. Disability as Life with Possibilities
List of Appendices


Appendix 2. Data Analysis Sheet

Appendix 3. Preliminary Data Analysis Patterns

Appendix 4. Three Dimensional Analysis
Chapter 1
Research Paradigm and Research Question

“...Man, through the use of his hands, as they are energized by his mind and will, can influence the state of his own health” (Reilly, 1962, p. 1)

Reilly’s quote from her Eleanor Clarke Slagle lecture in 1962 is arguably the most cited quote in the world of occupational therapy. The Eleanor Clarke Slagle Award and lecture are granted by the American Association of Occupational Therapists to honour an outstanding occupational therapist in research, education, and/or clinical practice in the United States of America. While most occupational therapists in English-speaking social contexts are familiar with Reilly’s statement, the words themselves can elicit pause for critical reflection. Notwithstanding gender-specific language, Reilly’s words express very particular meanings about occupational therapy’s views of health, the body, and the mind. A reader of this passage who is unfamiliar with the discourse of the profession of occupational therapy could raise the following questions:

- Are the body and mind considered separate entities (with the body energized by the mind)?
- If health lies in the use of your hands, what does this say about those who do not have use of their hands?
- Are unhealthy people responsible for their ill health due to a lack of either ‘will’ or the use of their body/hands?

Our ways of understanding the world are grounded in language, and the words we use and the meanings we attach to them shape social action. Smith (1990, p. 61) describes the significant consequences that texts have in society: “The result, an objectified world-in-common vested in texts, coordinates the acts, decisions, policies, and plans of actual subjects as the acts, decisions, policies and plans of large-scale organizations.” Smith goes on to acknowledge the hidden ways that language (through text) shapes our understandings of concepts: “In the textual mode, a knower’s only access to the object of knowledge is through its textual presence. The shaping of that presence by the social organization of its production is hidden but effective; the knower is related to the object of her knowledge through it” (p. 63). As such, language becomes of utmost importance.
Quotes such as Reilly’s, which are so pervasive in occupational therapy, can be critiqued as dogmatic; and yet, the words continue to have effects, not only on the profession of occupational therapy, but also on those who are served by the profession. While Reilly does not explicitly mention disability, her words convey implicit assumptions grounded in what could be considered an ableist perspective—which can be interpreted in relation to the three questions listed above. This text (Reilly’s quote) and others in occupational therapy offer ideal spaces in which to engage with the meaning of disability. Whenever disability is perceived, written about, or thought about, it is conceptualized in particular ways.

Titchkosky (2007) argues: “The ways that disability comes to have meaning have something to teach us about our life-worlds” (p. 12). In the context of this thesis, the ways that disability comes to have meaning in occupational therapy have something to teach us. The ways that disability is conceived in occupational therapy are directly related to the assessments and interventions that therapists choose to select. If disability is seen to be problematic, assessments and interventions are likely to focus on minimizing orremediating the disability. Moreover, if disability is seen to reside within the individual, appropriate interventions are targeted at the individual level. The implications of how disability is conceived in occupational therapy have a direct impact on the lives of clients. Therefore, given the importance of disability, and its presence in occupational therapy texts, I propose that we need to pause or slow down when we see words about the body or disability and when we think about the idea of disability, in order to consider how disability is conceptualized in occupational therapy. Smith captures this when she states, “If we don’t examine and explicate the boundaries set by the textual realities of the relations of ruling, their invisible determinations will continue to confine us” (p. 65).

1 Organization of Thesis

This thesis is organizationally structured with Chapter 1 focusing on the history of occupational therapy, the models or paradigms that have helped to shape conceptualizations of disability, an outline of the research question and paradigm, and a description of the philosophical framework that I have adopted in this work. In Chapter 2, I describe critical discourse analysis, the method that has been used to address the research question. An overview of the research design, data selection, and data analysis are also discussed. In Chapter 3, I explore discursive patterns used to address the nature of disability in occupational therapy literature. Textual analysis is presented
through the internal and external relations that are present in the text, and various extracts from the data are collated into figures that highlight the textual features of the data. In Chapter 4, I present a detailed analysis of the meaning of disability in occupational therapy texts through textual analysis of data extracted in figures, and through logical implications that are shown schematically. In Chapter 5, I discuss the discursive patterns related to the professional practices of occupational therapy, and I address the implications that various conceptualizations of disability have on the professional practice of occupational therapy.

2 History, Biomedicine, and Occupational Therapy

Western writers have often traced the philosophical roots of occupational therapy back to the ‘moral treatment’ movement originating in Europe in the nineteenth century (Schwartz, 2003; Peloquin, 1989; Bockoven, 1971). Moral treatment was known as a ‘humanitarian’ approach of compassion that embraced the importance of engaging in creative and recreational activities to restore mental health in individuals. This was before the rise of biomedicine as the dominant arbiter of truth with respect to matters of health in the industrialized world. The philosophy of moral treatment challenged previously accepted religious explanations for mental illness and proposed that mental illness could be explained by physical changes in the brain (Taubes, 1998). The decline of moral treatment by the turn of the 20th century was in part due to shifts in social and medical communities (Peloquin, 1989). Asylums providing moral treatment for people deemed mentally ill became increasingly overcrowded, and the conditions deteriorated, such that custodial care became the focus of the asylums. Shifts in the medical community towards the scientific inquiry of illnesses led to the discovery that mental illness was caused by lesions in the brain (Peloquin, 1989). As such, treatments focusing on the environmental or psychological components of mental illness (moral treatment) became unnecessary.

By the turn of the 20th century, moral treatment had mostly faded in Europe; however, the Arts and Crafts movement was just taking hold in North America. Proponents of this movement advocated for a return to a “simpler life in which the body and mind could be engaged in

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occupations that yielded fine hand-crafted objects” (Boris as cited by Schwartz, 2003, p. 7). Occupational therapy’s founders recognized the therapeutic value of creative and pleasurable occupations, and this value would become one of occupational therapy’s foundational pillars. In greater North American society, disabled people were stigmatized and marginalized from normal citizenship and participation in social life.

Well before the impact of electronic technologies, such as radio, television, and personal computers, entertainment took the form of live shows and performances and public displays and exhibitions at museums. Large travelling circuses typically included a ‘sideshow’ in which disabled people were featured and made to perform ‘freakish acts’ (Garland-Thomson, 2005). The ‘freak show’ as described by Bogdan (1998) was a “formally organized exhibition of people with alleged and real physical, mental, or behavioural anomalies for amusement and profit” (p. 10). The exhibits drew crowds of people, including reputable scientists and physicians who were curious to see human oddities. Curatorial practices at museums also included displaying physically anomalous bodies and artifacts for public entertainment (Sandell, Delin, Dodd, & Gay, 2005). The stigma of disablement extended to other areas of social life, particularly in the interface between society and science.

The practice of exhibiting people with differences for profit and amusement declined as Mendel’s laws of genetics were applied to human traits (Bogdan, 1998). People with abnormalities were increasingly seen to have genetically inherited the traits, giving rise to the eugenics movement. “Human differences became medicalized as pathological—as ‘disease.’” (Bogdan, p. 63). From the 1800s to as late as 1970 in Canada, eugenics legislation endorsed the involuntary sterilization of persons deemed unfit or unsuitable to procreate, particularly those deemed ‘mentally defective’ (Grekul, Krahn, & Odynak, 2004). Sterilization legislation was coordinated with segregation laws, which saw ‘undesirables’ institutionalized in asylums or work farms (Grekul et al., 2004).

In response to forced interventions for ‘undesirables,’ disability groups began to form within institutions. The 1960s and 1970s marked a time when social movements—including the disability rights movement and independent living movement—emerged (Zames & Zames, 2001). These social movements formed when groups of disadvantaged people rallied together to form and manage their own organizations with the goal of having their needs heard and met.
Henry Enns, a prominent disability rights activist and pioneer of the Canadian disability rights movement, largely influenced disability rights movements internationally (Disabled Peoples’ International, 2015). His work was seen as instrumental to the development of Disabled Peoples’ International (DPI), an international organization of people with disabilities, founded in the early 1980s. Enns is considered a particularly important figure in the history of Canadian disability rights. As a recipient of the Occupational Therapists of Canada Independent Living Award, he and his work have likely influenced a number of Canadian occupational therapists.

Things also changed with the ascent of science and biomedicine. Scientific discoveries in the twentieth century resulted in improved medical care and growing emphasis on establishing and demonstrating the scientific effectiveness of interventions. Early occupational therapists realized the strategic importance of aligning occupational therapy with medicine, and they advocated for the profession’s status within the medical disciplines (allied health professions). Following World War II, and given the number of injured soldiers returning from war, the demand for occupational therapy increased, especially in military hospitals. The focus of interventions changed at that time from arts and crafts to functional, job-related occupations. The importance of possessing specialized and technical skills became pivotal to efforts to increase the profession’s status and ensure its survival in a medicalized society (Friedland, 1997). As a result, occupational therapy curricula were changed to reflect the need for more specialized technical skills.

Hooper and Wood (2002) identified a tension between what the founders of occupational therapy valued (creative and pleasurable occupations), on the one hand, and the value of biomedical ‘science’ and a more specialized technically-based profession, on the other. The influences of this fundamental tension are apparent in the theoretical discourses that emerged in occupational therapy later in the 20th century. In one way or another, the development of theoretical frameworks, models, assessment batteries and instruments, and practice protocols in occupational therapy would reflect the values of a more specialized, technical profession based on biomedical science (Schwartz, 2003). For example, the Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists, 1997), which guides occupational therapy in Canada, reflects the value of individuals’ functional control over circumstances. The Model of Human Occupation (Kielhofner, 1980a, 1980b), first published in 1980, proposed a framework for clinical and research application based on empirical evidence.
The Model of Human Occupation and associated assessment batteries are based on the central tenet that human beings function as systems of volition, habituation, and performance (Kielhofner & Burke, 1980). Various other assessment instruments and treatment approaches that have developed—including the Assessment of Motor and Process Skills (Fisher, 1995), Rivermead Perceptual Assessment Battery (Whiting, Lincoln, Bhavnani, & Cockburn, 1985), Neurodevelopmental Treatment Approach (Bobath, 1963), and Constraint-Induced Therapy (Taub, 1994)—reflect a more specialized, technical profession.

Over the last century, leaders of occupational therapy have expanded the profession’s foundational basis and reasoning, purpose and role in the healthcare system, and procedures and methods to align with historical shifts in medical thinking. Despite this progress, a fundamental construct has been problematically overlooked and under-theorized: while critical discussion around the concept of ‘occupation’ (Hammell, 2004) and some other concepts considered core to occupational therapy is building, the construct of ‘disability’ has been largely ignored. Assumptions about what disability might mean are embedded in the profession’s philosophy, theory, literature, and practice; however, very little critical examination has been enacted in terms of what disability could mean in the context of occupational therapy. It is understood that one of the intended outcomes of occupational therapy is to minimize disability itself thus, it behooves us to critically examine the very construct that is often the primary focus of therapeutic interventions. This examination should include how disability is defined and how it shapes occupational therapy.

In occupational therapy, is disability assumed to be an individual-centric phenomenon, such as a personal tragedy (Oliver, 1990)—an embodied condition that requires fixing, resulting in bodies that should be returned to a certain universal standard of normal? If disability is conceived as a problem with the body, the focus of occupational therapy intervention will naturally be geared towards remediating the body or the person. Alternatively, is disability comprehended as a socially located phenomena requiring societal or environmental intervention? If disability is conceived as a societal problem, the focus of occupational therapy intervention will be geared towards social and environmental change.

Such questions surrounding the nature of disability, including the ways that disability is conceived, suggest there are different models or paradigms for understanding disability. While
models and paradigms of disability are abstract in nature, they have tangible implications and consequences. Occupational therapy professionals’ selection of assessment tools and intervention strategies is guided by overarching theories, frameworks, and models of disability. Thus, to begin to address questions surrounding the nature of disability in occupational therapy, we need to take a closer look at the models or paradigms of disability.

3 Models and Paradigms of Disability

Theoretical frameworks, approaches, models, and paradigms are useful tools to help support decision-making among healthcare professionals. Hubbard (2004) describes the necessity of models or paradigms of disability for guiding healthcare professionals’ perceptions in working with disabled people to enhance their futures and facilitate resources. Professionals depend on the models, paradigms, and approaches that are available to them in their selection of assessment tools and intervention strategies (Finkelstein, 1996). For example, compensatory approaches are well established in occupational therapy theory. Using a compensatory theoretical approach, an occupational therapist is likely to see underlying impairments as irremediable and will thus focus assessment and intervention strategies on adaptation (e.g., adaptive devices or equipment) or environmental modification. This is to say, the consequences of drawing upon particular models or paradigms of disability will necessarily allow for particular interventions while precluding others. I will now describe several models or paradigms of disability that are accessible and available to occupational therapists in Canada.

3.1 Medical or individual model

Several models of disability have emerged; however, historically the medical model of disability has predominantly influenced healthcare and rehabilitation (Hammell, 2006; Finkelstein, 1996; Marks, 1996). The medical or individual model of disability locates disability in the individual and emphasizes limitations in physical functioning (Hubbard, 2004; Oliver, 1983). Disability is seen as a restriction in abilities to perform tasks as a result of a biological condition, which lies outside of normal human functioning (Finkelstein, 1996; Marks, 1996; Terzi, 2004). In turn, social disadvantage is deemed to be the inevitable and tragic consequence of this abnormality or impairment, implying that without a cure for the impairment, social inclusion is difficult if not impossible to attain (Hammell, 2006). Within the medical model, treatment is focused on curing individuals in order to return them to normalcy (Hubbard, 2004; Shakespeare, 2013).
3.2 Economic model

Rather than reducing illness to disordered bodily functions, the economic model of disability emphasizes a limited ability to work (Hahn, 1985; Hubbard, 2004; Oliver, 1990). This model is based on the premise that work is a major social priority in society, and it assumes that disabled people are less efficient from a human resources standpoint compared to their non-disabled counterparts (Hubbard, 2004; Rioux, 1997). Disabled people incur a cost to society by consuming extra resources and having limited ability to work. Similar to the medical model of disability, the economic model locates disability in the individual and does not recognize social sources of disability (Hubbard, 2004).

3.3 Functional-limitation paradigm

According to the functional-limitation paradigm, “disability is considered the expression of a physical or mental limitation in a social context” (Hubbard, 2004, p. 185). This view of disability focuses on social function rather than the biological condition/impairment, and it assumes that a person may be disabled in one context but not in another. A collection of models—including the Nagi model (Nagi, 1965), the Disability Creation Process model (DCP) (Fougeyrollas, Cloutier, Bergeron, Cote, & St. Michel, 1999), and the World Health Organization (WHO) International Classification of Functioning, Disability and Health model (ICF) (WHO, 2001)—are based on the functional-limitation paradigm, and they collectively assume that the “interaction of…physical or mental limitations with social and environmental factors determines…disability” (Hubbard, 2004, p. 185). Occupational therapy theory is mostly consistent with the functional-limitation paradigm, which currently shapes healthcare curricula in Canada (Hubbard, 2004). Although occupational therapy has adopted a client-centred focus, it can be argued that the assumption remains that disabled people require the resources of rehabilitation professionals to help them achieve their goals by improving physical functioning, or adapting tasks or environments (Hammell, 2006).

3.4 Social model

The social model of disability emerged from the distinction between impairment and disability that was made by the Union of the Physically Impaired Against Segregation (1975). The term ‘social model of disability’ was coined by Michael Oliver (1983), who initially conceptualized
the social model of disability in opposition to the individual or medical model of disability. The theoretical underpinnings and perspectives of the social model of disability are based on the concepts of equal treatment, equal access, and a ‘right’ to participate fully in society (Hubbard, 2004; Oliver, 1990; Shakespeare, 2013).

Some critical disability theorists and proponents of the social model of disability argue that disability is not located within the individual, but is rather a product of the interaction between humans and their environments—with an emphasis on the social, cultural, economic, and institutional environments (Finkelstein, 1996; Hubbard, 2004; Oliver, 1983). While there are a multitude of social-relational approaches to conceptualizing disability, these models primarily rely upon the notion that it is society’s inability to adjust and/or accommodate to the needs and desires of people with impairments that produce disability, rather than the inability of people with impairments to adjust to and modify the demands of society (Marks, 1996; Oliver, 1983; Oliver, 2000; Shakespeare, 2013; Finkelstein, 2007; Finkelstein, 1996; Hubbard, 2004). Within the social model, issues of marginalization, exclusion, oppression, and discrimination are examined in terms of ‘disabling’ processes that, when imposed on top of impairments, cause disability (Hammell, 2006). Treatment based on the social model calls for rehabilitation professionals to advocate for social change (Kielhofner, 2005), rather than focusing on remediating the disability at the individual level.

4 Research Paradigm

In my research, I adopt an overarching critical theoretical approach informed by social constructionism to examine the meaning of disability within the profession of occupational therapy. Hammell (2006, 2007) outlines the beginnings of what she coins a ‘disability methodology,’ or a philosophical ethical approach to developing knowledge. Hammell proposes that a disability methodology is compatible with the client-centred philosophy of occupational therapy, and she emphasizes that research must incorporate a “reflexive, critical stance towards the conventional assumptions about disability” (2007, p. 367). I adopt this stance in my research, by examining taken-for-granted assumptions about disability through a reflective and critical lens that is qualitative in nature.

A qualitative approach to the research is justified because the aim of qualitative research is not to uncover pre-existing truths but to uncover meaning. Moreover, it is conducive to revealing the
hidden interactions of cultural attitudes, policies, and processes. I adopt the assumption that reality is subjective and that multiple truths may coexist (tenets of social constructionism to be discussed in section 6.2). The ontological and epistemological assumptions underlying the methodological approach fit within a critical social science perspective. More specifically, critical discourse analysis is used as a method to uncover how disability is constructed in occupational therapy.

4.1 Situating the research

In my research, I adopt a critical approach to disability as a field of study within occupational therapy. I am conducting my research at a time when critical, postmodern, and social constructionist researchers have written critiques of the rehabilitation professions. More specifically, researchers have called for a renewed way of thinking about disability in the rehabilitation sciences (Abberley, 1995; Hammell, 2006; Hooper & Wood, 2002; Roush & Sharby, 2011). Criticisms of the medical model in rehabilitation are becoming more common, and the social model of disability is gaining wider acceptance in the rehabilitation professions. Despite the growing acceptance of alternative views of disability, a thorough analysis of how disability is (re)constructed in occupational therapy literature has yet to be completed. Thus, it is an appropriate time to consider social constructionist approaches to examining disability in occupational therapy literature.

I am conducting my research from within the field of occupational therapy. I came to be interested in examining disability from a social constructionist perspective after several critical moments that I experienced with clients. Most notably, while in the final stages of completing my education as an occupational therapist, I was offered an opportunity to consolidate my learning in Haiti. I was informed that I would be working with local children in various orphanages, and I prepared for this experience by reviewing the assessment tools and intervention strategies that would be appropriate for working with children. I felt confident and well prepared for this experience, and I was looking forward to the opportunity to apply the knowledge I had gained in my two years of occupational therapy education. I hadn’t prepared myself for the shocking realization that I would need to put these assessment tools and intervention strategies aside—I wasn’t prepared to learn that everything I thought was true about disability could in fact be irrelevant. Within moments of working in this foreign environment, I
discovered that needed to *re-learn* most of what I had come to understand about disability and occupational therapy’s role in addressing it (see Iwama, Thomson, & Macdonald, 2011). I went on to practise occupational therapy in a remote northern location in Canada and in the Middle East, with each experience providing new learning and new ways to understand disability.

The challenges that I faced in relation to my own views of disability, particularly when they conflicted with the views of clients, were not isolated. I have also observed similar tensions in other health disciplines in a rehabilitation hospital setting, and I propose that a better understanding of the meaning of disability in the broader context of rehabilitation sciences would benefit all health disciplines. The tensions that I experienced inspired me to take a deeper look at how the phenomenon of disability has been constructed and continues to be reconstructed in occupational therapy.

In addition, I have transitioned from a clinical position in an academic hospital to a leadership position. I have become even more aware of the importance and impact of language and language choices when holding a position of influence in a healthcare setting. I am interested in examining the ways that disability is discoursed among Canadian occupational therapy leaders, particularly given the influence that they have within the profession.

5 Research Question and Objectives

My research question is: How is disability constructed in occupational therapy literature? This question grows out of my interest in unpacking the significance of ‘disability’ by engaging its meaning as it appears through an examination of selected texts in occupational therapy literature. Examining how disability is written about in occupational therapy literature will reveal much about how occupational therapy professionals define, understand, and address this fundamental construct. The objectives of my research include examining:

1. How is disability presented in OT literature?

2. What does this tells us about the ideological, political, and theoretical underpinnings of disability?

3. What are the dominant discourses of disability in occupational therapy literature?
To address my research question and objectives, I have analyzed influential Canadian occupational therapy texts (see Chapter 2). My research is theoretically informed by social constructionism and discursive scholarship in the social sciences. In the following sections, I discuss social constructionism and the discourse analytic principles/tenets that I have adopted.

6 Philosophical Framework

6.1 Epistemology

Epistemology is the branch of philosophy that deals with the theory and nature of knowledge (Burr, 1995). More simply stated, it is the way that we look at the world and make sense of it (Burr, 1995). Questions surrounding the nature and extent of knowledge include: How is knowledge acquired or constructed? How much can we know? What are the limits? IWama (2003) claims that much of what we ‘know’ about occupational therapy depends on whether one views ontology (the nature of things or existence) and epistemology (the way we make sense of the world) as situated outside the person—whereby knowledge and truths are sought in the external world—or as internal to the person and relative to their experiences.

In the Western collective experience, much of the knowledge that we acquire in life is gained through empirical or scientific learning or scholarship, or positivist traditions. Positivism seeks to uncover knowledge through observation, calculation, or experimentation. Knowledge about the world in the positivist paradigm exists in nature and can be directly observed. That which is observed and confirmed through experimental study and empirical data is deemed to be the truth or true knowledge. This is consistent with the multitude of scientific discoveries in the twentieth century that had a significant impact on medicine and rehabilitation professionals, who were ultimately granted expert status in matters related to the body and health.

Illich (1977) proposes that the mid-twentieth century should be named “The Age of Disabling Professions” (p. 11), characterizing the era as one where people with problems seek solutions from experts with knowledge. Illich goes on to assert that, through professional dominance, “…professionals assert secret knowledge about human nature, knowledge which only they have the right to dispense. They claim a monopoly over the definition of deviance and the remedies needed” (p. 19). Drawing on positivist traditions, medicine and the rehabilitation professions gained legitimacy, power, and elite status by developing specialized knowledge that would

Much of the literature surrounding disability in medicine and rehabilitation is similarly framed in a positivist paradigm, in which knowledge about disability is constructed and confirmed using experimental designs. The government of Canada regularly employs a positivist framework when collecting information from citizens. Statistics Canada reports on the number of people with disabilities, as well as the impacts that disability has on society (Titchkosky, 2007). This way of knowing disability is grounded in positivism. In this paradigm, disability is an individual embodied experience that can be quantified and statistically calculated in terms of incidence and prevalence in society. With universal definitions of disability developed by WHO, disability (as a thing and ‘marker of embodied distinction’) can now be calculated and compared across countries and geographical boundaries. Interventions geared towards ameliorating disability are studied through experimental design.

Clinical practice guidelines that guide therapists in making treatment decisions are developed as universal standards of care, based on certain truths about disability. Because disability is a core concept in occupational therapy, it is appropriate to consider the ways that knowledge surrounding disability is (re)constructed in the profession. In order to examine the concept of disability, I have chosen to take an alternative approach to the positivist approach described above, which is evident in much of the disability literature.

6.2 Social constructionism

The epistemological paradigm of social constructionism provides the overarching theoretical framework for my research. Although social constructionism is often considered a marginal perspective in occupational therapy and other health sciences, it provides the necessary backdrop for critically examining occupational therapy texts (Grant et al., 1999). One way that social constructionism emerged as a theoretical perspective was through Berger and Luckmann’s (1980) *The Social Construction of Reality*. As a theoretical perspective, social constructionism is influenced by ethnomethodology, phenomenology, and symbolic interactionism. Although there is no consensus about a universal definition of social constructionism, Burr (1995) describes the things you would need to believe in and do in order to be a social constructionist:
1) A critical stance towards taken-for-granted knowledge: “Social constructionism cautions us to be ever suspicious of our assumptions about how the world appears to be” (p. 3).

2) Historical and cultural specificity: Burr claims that all ways of knowing and understanding are historically and culturally relative.

3) Knowledge is sustained by social processes: “What we regard as truth…is a product not of objective observation of the world but of the social processes and interactions in which people are constantly engaged with each other” (p. 4).

4) Knowledge and social action go together: Social constructionism contends that knowledge and social action are linked, meaning that certain descriptions of the world sustain certain patterns of social action while excluding others.

In contrast to a positivist approach, social constructionism is grounded in a postmodern perspective, a movement that represents a questioning of assumptions commonly assumed to be true from a modern or positivist paradigm. The impact of postmodern perspectives in literary criticism has resulted in an understanding that no true ‘reading’ of a text is possible, and as such, texts are always interpretive in nature (Burr, 1995). Secondly, an important consideration when analyzing text from a postmodern perspective is the notion that the meaning that an author intended in their text is irrelevant (Burr, 1995, p. 13).

Given that social constructionism, as described by Burr, is grounded in the fundamental principle that language is a pre-condition for thought (i.e., the way people think is based on language) and a form of social action (i.e., language necessarily implies social action), it is not surprising that discourse analysis is one of the most favoured methods of inquiry used by social constructionists (Wilkinson, 2001). The primary focus of interest for discourse analysis is language (more broadly, semiotics), which is consistent with a social constructionist perspective that language is of central importance in how we come to know and understand concepts in the world. I discuss discourse analysis further in Chapter 2.

The main limitation or criticism of research conducted from a social constructionist perspective is the perception that the research lacks ‘objectivity.’ Of course, this argument is grounded in a positivist perspective—that there is one singular view of the truth and therefore one correct
interpretation of a ‘reading’ of text in textual analysis. This represents an obvious incongruence between the two epistemological perspectives discussed, as it relates to concepts such as health and disability.
Chapter 2
Methods

1 Critical Discourse Analysis

The method of inquiry that I have chosen is critical discourse analysis, and more specifically a method based on the work of Fairclough (1992, 2003). There are many interpretations of the term discourse, steeped in different disciplinary origins of discourse analysis, including branches of philosophy, linguistics, and sociology (Fairclough, 2003; Burr, 1995). I have chosen to use the term discourse to mean spoken and written forms of language (talk and text) as social practice (Fairclough, 2003; Wood & Kroger, 2000). Critical discourse analysis is “…based upon the assumption that language is an irreducible part of social life, dialectically interconnected with other elements of social life, so that social analysis and research always has to take account of language” (Fairclough, 2003, p. 2). While discourse analysis has been commonly used as a method by researchers in nursing and medicine, it has only recently been recognized as an appropriate method for qualitative research exploring representations of health and illness in therapies (Ballinger & Payne, 2000; Chamberlain, Stephens, & Lyons, 1997). This is supported by a review that was conducted to map the nature and distribution of studies that have utilized discourse analysis as a research method in occupational therapy and physiotherapy. The researchers concluded that the small but increasing number of published studies utilizing discourse analysis signaled that it was a relatively new method in the rehabilitation sciences (Macdonald, Thomson, & Iwama, 2012).

Fairclough (1992) describes five theoretical propositions that frame his approach to critical discourse analysis. My research is founded on these five theoretical propositions:

1) Discourse shapes and is shaped by society: Discourse (language) changes depending on context, and situations themselves are altered by language choice.

2) Discourse helps to create (and change) knowledge, social relations, and identity: The way that language is used shapes the way we think about things (e.g., disability).
3) Discourse is shaped by relations of power and invested with ideologies: Certain language and choice of words are reflective of power and ideologies invested in discourse. (e.g., *dis-ability* assumes that disability is outside of normal human functioning).

4) The shaping of discourse is a stake in power struggles: If discourse is shaped by power, then language can be seen as a powerful tool for social control and social change.

5) The goal of critical discourse analysis is to show how society and discourse shape each other: Language is neither neutral nor transparent, but is rather concerned with raising consciousness of the issue.

I use an approach in my research that is based upon Fairclough’s interrelated three-dimensional conceptualization of discourse—and correspondingly, a three-dimensional method of discourse analysis. In Fairclough’s approach (1992), discourse is seen as: text (language that is spoken or written), discourse practice (text production, distribution, consumption, and interpretation), and socio-cultural practice (social, historical, and cultural context). Fairclough (2003) asserts that an analyst must be concerned with all ‘levels’ of discourse and take a relational approach to textual analysis, whereby the levels of text, discursive practice, and social practice are dialectically related to one another. The levels are interrelated in nature (not discrete) and separated for analytic purposes only.

Figure 1 represents Fairclough’s (1992) three-dimensional view of discourse analysis (University of Strathclyde, n.d). The three-dimensional nature of Fairclough’s levels of analysis is depicted visually by embedding each dimension within one another. This represents the interrelated nature of the dimensions themselves, their interdependence on one another, and the ability for analysis and thoughts to flow in both directions between the three dimensions. The distinctions between text, discursive practice, and social practice are not meant to suggest that these concepts are separate and distinct from one another, but rather there is relationship between the concepts and dimensions. The three dimensions represent three points of analysis that Fairclough (1992) proposes are necessary for critical discourse analysis.

At the micro-level, I am interested in examining the structure of text, including its syntax and format. At the meso-level, I analyze text production and consumption while focusing on how power relations are enacted. Finally, at the macro-level, I am concerned with an inter-textual
understanding, including a focus on determining the broad socio-political and socio-historical contexts that affect the texts.

Figure 1. Three Dimensional View of Discourse and Discourse Analysis (Fairclough, 1992)

Several approaches to critical discourse analysis exist, grounded not only in philosophical traditions, but also in the style of analysis of the text. Fine-grained analysis often involves a detailed focus on the language and linguistic features of the text (Edwards & Potter, 1992). This micro-approach to analyzing text is consistent with discursive social psychology, as initially described by Edwards and Potter (1992), and conversation analysis, an approach developed by Sacks and colleagues (1974). Alternatively, thematic analysis is often an approach that focuses more on social theoretical issues (Fairclough, 2003). I see these approaches to critical discourse analysis as complementary, and I have adopted a method of analysis in which I consider the linguistic features of selected texts within a particular socio-cultural/political context. This approach is supported by Fairclough, who proposes:

This is not, or should not be, an ‘either/or’. On the one hand, any analysis of texts, which aims to be significant in social scientific terms, has to connect with theoretical questions about discourse (e.g., the socially constructive effects of discourse). On the other hand, no real understanding of the social effects of discourse is possible without looking closely at what happens when people talk or write. (Fairclough, 2003, p. 3)
1.1 Data selection

Critical discourse analysis calls for a close examination of texts that are deemed politically or culturally influential to a given society, otherwise referred to as texts that have an impact (Fairclough, 2003). Taylor (2001) proposes that analysts “select documents because they are not broadly representative but highly specific…worthy of analysis because, for example, they are associated with powerful or well-known people” (p. 25). Fairclough (1992) proposes that a sample of texts be selected for detailed analysis on the basis of a preliminary survey of texts that are the focus of the study. Given the importance of analyzing social practices (social, cultural, and historical contexts) as they relate to the text, I have limited the data selected for my study to occupational therapy texts published in Canada. After a preliminary review of a large number of influential texts in occupational therapy literature (including seminal papers, key reference books, and international lectureships), I have chosen to examine texts from the Canadian Association of Occupational Therapists’ Muriel Driver Lectureships as published in the *Muriel Driver Memorial Lecture Anthology* (Canadian Association of Occupational Therapists, 2001).

The Muriel Driver Lectureship was established in 1975 to honour the legacy of Ms. Muriel Driver, who contributed to the profession of occupational therapy for over 30 years. The Muriel Driver Lectureship is considered the most prestigious award and the highest honour in Canadian occupational therapy. The award is bestowed upon an occupational therapist that has made outstanding contributions to the profession through clinical practice, administrative leadership, professional volunteerism, and/or the education of future occupational therapists (Finlayson, 2008). The Muriel Driver Lectureship Award is presented, and the lecture is delivered, at the Canadian Association of Occupational Therapists annual conference. The lecture is subsequently published in the *Canadian Journal of Occupational Therapy*, which is available at no cost to members of the Canadian Association of Occupational Therapists. The Canadian Association of Occupational Therapists (2001) also published a *Muriel Driver Memorial Lecture Anthology*.

Muriel Driver lecturers have challenged the profession of occupational therapy and raised key critical questions that are often uncomfortable to answer (Finlayson, 2008). Those who have been selected to deliver the Muriel Driver Lectureships have “knowledge, experience and ability to challenge yet simultaneously *encourage and support* us to take on these challenges to move forward in some way” (Finlayson, 2008, p. 195). The highly influential nature of the Muriel
Driver Lectureships given by leaders in Canadian occupational therapy makes these texts ideal for analysis.

1.2 Design

I have chosen an intensive design rather than an extensive design for my research. Intensive designs are composed of detailed analyses of a smaller number of sources, rather than a comprehensive overview of a large number of sources. The amount of material (in this case, lectureships) to be included in a critical discourse analysis is hard to define prior to beginning the process of data collection and analysis (Fairclough, 1992; Potter & Wetherell, 1987). The sample is complete once it is deemed to represent the discursive patterns that fall within the domain of the study (i.e., discursive patterns surrounding disability). Potter and Wetherell (1987) caution analysts from getting bogged down in so much data that they cannot uncover the linguistic detail and patterns. As such, data collection for my study has been an ongoing and iterative process that I undertook simultaneously with data analysis to ensure that the data set represents the discursive patterns surrounding disability in occupational therapy literature. In order to ensure an appropriate historical perspective on the discourses of disability in the profession, I have included at least two data sources (lectures) from each of the four complete decades of data available from the Muriel Driver Lectureships (1975-1979, 1980-1989, 1990-1999, 2000-2009). Given that I am conducting my research mid-way through a decade, the sample of data for 2010-2019 is incomplete, and I have not included it in my study.

1.3 Criteria for inclusion of texts

Each of the 31 Muriel Driver Lectureships from 1975-2009 published in the Muriel Driver Memorial Lecture Anthology (Canadian Association of Occupational Therapists, 2001) was reviewed in detail to consider their potential inclusion in my study (see Appendix 1). Only one lecture was delivered in French, and while it was initially reviewed, I excluded it from further detailed analysis. A series of questions were then developed and applied to each Muriel Driver Lectureship from 1975-2009, based on the Muriel Driver Memorial Lecture Anthology (Canadian Association of Occupational Therapists, 2001) (see Table 1). I used these questions as guiding criteria to select lectures that would be most relevant to uncovering the ways that disability has been constructed in occupational therapy over time. I selected a minimum of two, and maximum of three, lectures from each of the four decades of complete data to enable
consideration of discursive patterns and social context over the course of the Muriel Driver Lectureships. When more than three lectures met the minimum criteria for inclusion, which was the case for lectures from 1990-1999, I conducted a further review of the texts and selected three deemed most relevant to the examination of disability.

I applied the following questions to the 30 English-language Muriel Driver Lectureships as criteria for inclusion in the study:

1) Is the word disability used in the title, keywords, or abstract?

2) Is the word disability used in the headings or sub-headings in the text?

3) Are there visual images or graphics in the text that represent disability?

4) Are models or paradigms of disability or health discussed in the text?

Table 1. Data Selection

<table>
<thead>
<tr>
<th>Year</th>
<th>Title, keywords, abstract</th>
<th>Headings, sub-headings</th>
<th>Visual images, graphics</th>
<th>Models or paradigms</th>
<th>Selected for analysis</th>
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1992
1993 Abstract
1994
1997
1999
2000 Title, keywords Headings
2001
2002
2003
2004
2005 Abstract Yes Yes ✓
2006 Abstract, keywords Sub-headings Yes ✓
2007
2008
2009

Note: Shading in Table 1 is used to differentiate each decade

1.4 Data analysis

Potter and Wetherell (1987) propose there is no recipe-style method for analyzing discourse. This proposition is supported by Rogers (2004), who reviewed literature to examine methods for conducting discourse analysis and found that no one approach is consistently adopted. Their findings suggest that various methods are often used simultaneously in order to address research aims.

The approach to analysis that I have adopted is based on deconstruction. I have analyzed texts by taking them apart to examine how they are constructed in ways that (re)produce particular views of disability. I have combined deconstruction with the search for and reconstruction of discursive patterns pertaining to ideal, alternative, and contradictory conceptions of disability.
To begin, I read and re-read the data for various different purposes. I completed the first reading to extract from the data what a ‘typical reader’ may take away from the text. I took a more critical approach in subsequent readings of the data, searching for and examining descriptions, structures, discursive patterns, and social practices that are present in the text. Using a social constructionist framework, I focused on the constructive and functional dimensions of the discourse, while coupling this with what Potter and Wetherell (1987) call “the reader’s skill in identifying patterns of consistency and variation” (p. 169).

A data analysis template based on Fairclough’s three-dimensional approach to critical discourse analysis was developed (see Appendix 2). The template was used to guide different levels of analysis, extracting data from the texts and collating the extracted data into a spreadsheet for further detailed analysis and review (see Appendix 3). I then organized the data into three categories that correspond with Fairclough’s three-dimensional approach to critical discourse analysis (see Appendix 4). In the final stages of analysis and preparation of my dissertation, I extracted relevant data from the spreadsheet in the form of quotations, taken directly from the texts, and collated the textual samples into figures that I will present in Chapters 3 and 4. I reviewed the quotations extracted from the texts at the most detailed textual level (including sentence structure, vocabulary, and syntax) drawing on Fairclough’s (1992) three dimensions or levels of analysis: text analysis (description), process analysis (interpretation), and social analysis (explanation). The levels of analysis are described in further detail below.

1.4.1  Text analysis (description)

At the level of text analysis (description), Fairclough (2003) refers to both internal and external relations. I have used these broad categories as described by Fairclough to frame my analysis of the texts. The internal relations that have guided my analysis include: semantic relations, grammatical relations, vocabulary/lexical relations, and phonological relations. Below, I briefly describe the internal relations, which I discuss in further detail in Chapters 3 and 4.

Semantic relations are those that exist between words and expressions, and between sentences and clauses. The main semantic relations that are of interest in the study are causal relations (e.g., disability is the result of/cause by a condition or disease) and higher-level or global semantic relations, such as the ‘problem-solution’ relation (Hoey, 2001). ‘Problem-solution’ relations are
built when problems are presented in texts and solutions are proposed (e.g., disability is seen as a problem that can be addressed by occupational therapy).

Grammatical relations exist at the level of morphemes within a word (‘dis’ and ‘ability,’ ‘ill’ and ‘ness,’ ‘dys’ and ‘function’), between words and phrases, between phrases and clauses, and between clauses and sentences. Relations between clauses and sentences that are *paratactically* related are also of interest in this study; such relations are considered grammatically ‘equal’ or ‘coordinate’ through the use of coordinating conjunctions (e.g., disability and illness, disability or illness, disability or disease, disability and dysfunction).

Vocabulary/lexical relations include choices of language that reflect relationships between words that are collocated (i.e., relations of collocation) or the co-occurrence between words or expressions. Vocabulary/lexical relations, and specifically relations of collocation (e.g., disability and illness, disability and disease, disability and dysfunction), are of particular interest in the study. Fairclough (2003) describes one method of determining these relations, “through looking at collocations, patterns of co-occurrence of words in texts, simply looking at which other words most frequently precede and follow any word which is in focus, either immediately or two, three, and so on words away” (p. 131). He goes on to say: “Sometimes one is struck by collocations in particular texts” (p. 131). While the most effective way to determine and examine collocational patterns is through computer-assisted corpus analysis, I used manual examination in my study.

Finally, phonological relations in spoken language refer to aspects of rhythm and intonation. Given that I analyzed the Muriel Driver Lectureships in written format, analysis at this level was not possible. Phonological relations also exist in written texts, and they refer to the graphological relations that exist when authors utilize different fonts, sizes, headings, sub-headings, etc. While I analyzed headings and sub-headings in the texts, as well as font sizes, this analysis was not central to my research.

I also examined internal relations as they relate to the representation of social actors (Fairclough, 2003). Social actors or participants in the text are represented in various ways, including: named/classified, whereby social actors are either named or classified by category (e.g., person with a disability, people with disabilities, disabled people); activated/passivated, whereby the activated social actor is actively doing and the passivated actor is affected by processes that are happening in the text (e.g., occupational therapists assist people with disabilities in achieving
independence); and finally, inclusion/exclusion, whereby social actors are excluded through techniques of suppression (i.e., they are absent from the text) or backgrounding (i.e., they are mentioned initially and inferred elsewhere).

The internal relations discussed above are present in the texts through syntagmatic (i.e., the words are present in the text) and paradigmatic (i.e., attention is drawn to the relations, but the words may not be present in the text; absences are noted) means (Fairclough, 2003). Fairclough also draws analysts’ attention to external relations that occur in the text, through references or summaries of outside texts (intertextuality) or through assumptions. Fairclough goes on to distinguish between various types of assumptions, including propositional assumptions and value assumptions. Propositional assumptions are related to what is, or what can be, or what will be; examples include dualist assumptions that may be pervasively assumed and taken for granted. Value assumptions are related to notions of what is good or desirable. Drawing on linguistic pragmatics, logical implications—whereby implicit meanings can be logically inferred through language—are also of particular interest in the study.

1.4.2 Processing analysis (interpretation)

At the level of processing analysis or interpretation, Fairclough (2003) asserts that relations between genres, discourses, and styles are important. These are referred to as interdiscursive relations, which lie at the intermediate level between texts themselves and the social context in which texts are produced. At this level, my analysis was guided by examining the nature of the ‘producer’ of the text: in this case, the influential nature of the lecturers who, by virtue of being given a Muriel Driver Lectureship award, are deemed authority figures in the field of Canadian occupational therapy. At the interpretation level of analysis, it is also imperative to consider the location (or what Bourdieu refers to as the ‘habitus’) of the lecturers, who are socialized professionally to act and view the world based on particular experiences. The location from which each lecture is delivered results in the lecturer talking or writing in certain ways, while precluding others.
1.4.3 Social analysis (explanation)

At the level of explanation, I paid particular attention to the social, historical, and cultural contexts in which the lectures were delivered. I make an attempt to identify and draw on particular socio-political and -historical events in my examination of the texts.

1.5 Limitations

Since I have adopted an approach that focuses heavily on language and linguistic features of text, I have chosen to consider only English-language texts. Although translated texts are often available and some researchers have used them in their analyses (Wodak, 1991; Yankah, 1991), I feel that it is critical to analyze text in the original language in order to fully consider language choice and political and discursive patterns. The Muriel Driver Lectureship delivered in 1983 was the only Muriel Driver Lectureship that I excluded based on language.

It is important to acknowledge that while I have grounded my research in social constructionism and adopted critical discourse analysis as a method based on Fairclough (1992, 2003), other approaches could have been taken. I have chosen to situate the research in relation to theorists including Vivian Burr and Norman Fairclough—and to focus on the internal and external relations within text. Alternatively, the study could have been situated in relation to social theorists such as Michel Foucault, and it could have focused instead on the complex social systems that produce and reinforce power (i.e., how do power relations influence and sustain the construction of disability in occupational therapy?). This alternative approach would have called for Foucauldian discourse analysis as both a methodology and method for conducting the research. Similarly, approaches to the research grounded in neo-liberal, post-colonial, or human rights discourses could have been taken and would have allowed for alternative analyses and interpretations of the data. The scope of my study was limited to examining how disability is constructed in occupational therapy literature, and more specifically focused on semiotic relations within Muriel Driver Lectureships.

Some scholars who consider the analysis from a positivist epistemological perspective may be concerned with the lack of ‘objectivity’ in my approach to textual analysis. However, if a qualitative and social constructionist ontological view is taken, there is no such thing as an ‘objective’ or ‘complete and definitive analysis’ of the text. What a text does (social action) is
not the same thing as what the text ‘objectively’ means. One of the key features of this type of approach to textual analysis is an acknowledgement that the analyst and her experiences become part of the analysis of the text itself.

1.6 Role of the researcher

The researcher plays a central role in critical discourse analysis. It is crucial for critical discourse analysts to be aware of and appreciate their role in the analysis of text (Van Dijk, 2001; Fairclough, 2001). A discourse analyst (as with any other researcher) brings a particular perspective and set of assumptions, values, beliefs, and biases to the research, which influences the research question, research methodology, and analysis (Smith, 1990). Burr addresses the role of the researcher in her description of theoretical assumptions that underlie discourse analysis as it relates to objectivity:

...objectivity is an impossibility, since each of us, of necessity must encounter the world from some perspective or other (from where we stand) and the questions we come to ask about that world, our theories and hypotheses, must also of necessity arise from the assumptions that are embedded in our perspective. No human being can step outside of her or his humanity and view the world from no position at all, which is what the idea of objectivity suggests...the task of researchers therefore becomes to acknowledge and even to work with their own intrinsic involvement in the research process and the part that this plays in the results that are produced. (Burr, 1995, p. 160)

I have taken an approach to my research that is consistent with a postmodern perspective—that multiple ‘readings’ or interpretations of the data are possible and no one interpretation represents the truth. My findings and interpretation of these findings represent an approach that, while systematic, is heavily influenced by the insider perspective that I bring to the research as an occupational therapist. Additionally, I come to the research identifying as female and non-disabled, and I recognize that these personal locations are important to consider in my role as researcher. While approaching my analysis of the text with an awareness of my role in the research, I have attempted to counter what Parker and Burman (1993) refer to as a disposition to ‘close’ the text, which limits alternative readings aside from one’s own perspective.
2 Ethics

I have limited the data selected for analysis to texts that are written and published in a publically available medium. The Muriel Driver Lectures were presented orally and subsequently published in *The Canadian Journal of Occupational Therapy*, a widely distributed publication. A *Muriel Driver Memorial Lecture Anthology* has also been published (Canadian Association of Occupational Therapists, 2001), providing the full series of lectures dating from 1975 to 2009. Data for the study was analyzed using the Muriel Driver Lectureships published in the anthology. The anthology is available for purchase from the Canadian Association of Occupational Therapists. Scholarship that does not involve human subjects need not be reviewed formally by a Research Ethics Board. Because the research data is publically available and no human subjects were involved, ethical review from a Research Ethics Board was not required for my research.
Chapter 3
What Is Disability?

1 Introduction

I present my analysis of this research in two parts: first I address how disability has been broadly defined, described, or depicted in the texts (Chapter 3); then I discuss the existential meaning of disability in the text—how disability has come to exist or is ascribed meaning (Chapter 4). In this chapter, I focus on the ‘text,’ or descriptive level of analysis. More specifically, what is disability as constructed in the text? What words and syntax are used to describe the construct of disability? More precisely, I describe consistencies and inconsistencies in the language that is used to describe disability in the data.

The epistemological paradigm of social constructionism provides the overarching theoretical framework for my research. Although social constructionism is a marginal perspective in occupational therapy and other health sciences (Grant et al., 1999), it provides the necessary backdrop for critically examining occupational therapy text. The premise that knowledge and social action are linked, and that a critical stance is necessary to uncover the flaws in our assumptions and conventional ideologies, forms the theoretical framework that underlies my research.

Wilkinson (2011) claims that discourse analysis is the most favoured method of inquiry used by social constructionists. Critical discourse analysis is aligned with the research question: How is disability constructed in occupational therapy text? I adopt an approach based on Fairclough’s (1992) interrelated three-dimensional conceptualization of discourse and correspondingly three-dimensional method of discourse analysis. Discourse and any discursive practice are seen as: a text (language that is spoken or written), a discourse practice (text production, distribution, consumption, and interpretation), and a socio-cultural practice (see Chapter 2 for detail).

2 The Language Struggle…‘Disability Etiquette’

Word choices are particularly important when examining texts and analyzing data using critical discourse analysis. Choice of language signals social, political, and literal meanings of various constructs, including disability. Figure 2 presents quotations taken directly from Muriel Driver
Lectureship texts (published in the *Muriel Driver Memorial Lecture Anthology*) that demonstrate inconsistencies in the choice of language, particularly around the concept of disability.

### 2.1 Representations of social actors

Social actors or participants in the text are represented in various ways, including: named/classified, whereby social actors are either named or classified by category (e.g., person with a disability, people with disabilities, disabled people); activated/passivated, whereby the activated social actor is actively doing and the passivated actor is affected by processes that are happening in the text (e.g., occupational therapists assist people with disabilities in achieving independence); and finally inclusion/exclusion, whereby social actors are excluded through techniques of suppression (i.e., they are absent from the text) or backgrounding (i.e., they are mentioned initially and inferred elsewhere).

Basset’s quote (1975), for example, uses classifications to represent social actors by referring to ‘the handicapped’ as those requiring the services of occupational therapy. In comparison, Carswell-Opzoomer (1990) uses ‘disabled people,’ and Law (1991) uses ‘people with disabilities.’ While these differences in language are subtle, they signal to the reader different interpretations and meanings, and they are derived in different social contexts.

More importantly, inconsistencies in language may in fact signal a struggle within the profession of occupational therapy. Is occupational therapy struggling to find the most appropriate language to reflect the values and philosophical assumptions that underlie core theoretical concepts within the profession? Do the shifting and inconsistencies in language reflect this struggle? Or does the shift in language in fact point to societal changes and contexts that shape what is considered appropriate in terms of language and social behavior?

Clinical and professional education in the health sciences often reaffirms dualistic beliefs, including the existence of concepts such as ‘right’ and ‘wrong’ in Western culture. The use of many different words or phrases to describe disability may allow for alternate possibilities. In this way, using classifications to represent social actors—such as ‘disabled people’ versus ‘people with disabilities’—may suggest to the reader that there is no ‘right’ way of speaking about disability. There is, however, the possibility that such inconsistencies in language may also confuse the reader.
Person-first language emphasizes the idea of ‘having’ a disability, versus ‘being’ a disabled person (identity-first language). Supporters of person-first language suggest that disability is an important part of the person, but it does not make up their identity. In other words, the disability is part of the life of a person but is not who the person has come to be. Disability does not define the person—they are people first who happen to be dealing with or working with an impairment, and impairment and personhood are understood to be separate issues. Person-first language is pervasive in health professional education and literature, as evidenced by textbooks and authorship guidelines of the majority of health professional and rehabilitation journals. This mechanism for describing disability has become the acceptable means of discussing people and constitutes disability etiquette.

In addition to the inconsistencies related to the concept of disability, the data also presents inconsistencies in words used to describe those who receive occupational therapy services. Many have resisted the word ‘patient’ because it is linked to medicine and implies passivity and a power differential. However, it remains the dominant language in many settings where occupational therapists practise (e.g., ‘inpatient rehabilitation’ in the hospital setting). Other words that are evident in the texts included ‘consumers’ and ‘clients.’ While the term ‘consumer’ elicits the image of someone consuming health services, it can also imply that the person ‘consuming’ the services is more educated and has more choice than a patient. The term ‘client’ is more obviously linked to client-centred practice (Rogers, 1951), which is one of the core foundations of Canadian occupational therapy (Canadian Association of Occupational Therapists, 1997) and an expectation in occupational therapy practice. These inconsistencies in the use of terminology may again signal to the reader a struggle in occupational therapy—or alternately, that there is no ‘right’ way to speak about the people that we work with.

Figure 2. Speaking About Disability

“We have also over the years developed skills in adapting equipment to fit the special requirements of the handicapped” (Basset, 1975, p. 2)

“The normal relationship negotiated between professional and client casts the client in the role of the person being helped” (O’Shea, 1977, p. 3)

“Our commitment to the service of disabled members of society has been the foundation
of practice and remains a motivation for many practitioners” (Stan, 1987, p. 2)

“The crux of the chronic pain patient’s dilemma: the agony of accepting the loss of old skills, the present sense of failure, and the fear of future uselessness” (Baptiste, 1988, p. 4)

“The present care system rarely if ever improves the lives of disabled people, persons with emotional or developmental disorders, socially disadvantaged persons, the elderly, or persons whose environment is harmful” (Carswell-Opzoomer, 1990, p. 2)

“Increasingly, people are concerned about the lack of rights of people with disabilities and the problems inherent within our environment which cause significant difficulties for people who have a disability” (Law, 1991, p. 2)

“Never in the history of Canada, or the disabled, have we been more challenged by diversity…As occupational therapists we should put all our energies into doing everything we can to ensure that diversity in any form, be it cultural, racial, or ability based, be tolerated. Not just tolerated, but respected. Not just respected, but celebrated” (Polatajko, 1992, p. 2)

“We interviewed sixteen people with recently acquired disabilities about spiritual issues that might have arisen for them since the onset of their disability” (McColl, 2000, p. 1)

“In the early stages of investigating the choices adults with physical disabilities make with respect to completing occupations” (Miller Polgar, 2006, p. 3)

“The attitudes of others are important influences on whether persons with disabilities will accept technology” (Miller Polgar, 2006, p. 5)

“When the consumer’s perception of assistive technology, the attitudes and behavior of others, and the institutional context are favorably disposed to assistive technology, then technology should act as an enabler for occupational participation” (Miller Polgar, 2006, p. 3)
3 Disability as a Problem…of Dysfunction

3.1 Textual analysis (description)

Despite the multitude of words (or classifications) that have been used to represent social actors in the data—from ‘the disabled,’ to ‘disabled people,’ to ‘people with disabilities’—what remains consistent is that disability is a thing to be described, discussed, and addressed by occupational therapists. Disability is one of the core concepts for occupational therapists interested in the relationship between disability and occupation. In the texts I examined, the concept of disability is often undefined, allowing for various interpretations and understandings. The lack of definition may suggest that the term is ‘naturalized’ in the text, with the writer assuming that it is absolute (undialogized language as described by Bakhktin) and requires no description. Alternatively, the lack of explicit definition of disability can be considered an inclusion/exclusion through backgrounding (Fairclough 2003), whereby a term is first used in a text and then inferred elsewhere in the text. An example would include using the term ‘disability’ initially, followed by terms such as ‘client’ or ‘patient’ elsewhere. Smith (1990) also relates the lack of need for explicit definitions to the power of concepts achieving factual status: “As the findings of a piece of research become taken for granted, they are finally incorporated into the texts of the discourse without reference to their source” (p. 66).

Assumptions are made about the nature of disability; however, it is rarely (if ever) constituted as something other than ‘negative.’ The ‘seriousness of the problem,’ as described by Basset (1975), and the ‘participation of people with mental health problems,’ which Desrosiers (2005) has identified, allow for one representation of disability. Not only is disability as referenced above a problem—but it is also a ‘serious problem.’ A problem, as defined by the Oxford English Dictionary (2014), is “a matter or situation regarded as unwelcome or harmful and needing to be dealt with and overcome.” The problematization of disability is evident throughout the texts (see Figure 3 for data extracted from the texts based on the Muriel Driver Memorial Lecture Anthology), and disability is framed as some ‘thing’ that can be fixed, ameliorated, minimized, treated, eliminated, or prevented by occupational therapists. The description of disability as a problem requiring a solution can also be described as a higher-level semantic relation, and more specifically as a problem-solution relation (Fairclough, 2003).
The disability itself, in this sense, is objectified and possessed by the person ‘with’ the disability. When disability is constructed as a problem (often requiring the professional help of an occupational therapist), it strengthens the rationale supporting person-first language, whereby the person and the disability (or problem) should be separated. Critical disability theorists have argued this point, further claiming that health professionals who adopt person-first language are continuing to perpetuate the stigma associated with disability: that disability is a problem or bad.

Assuming that disability is a problem (a value assumption about what is good and desirable) allows the reader to further question, what is the problem? Is it possible that the problem is truly a ‘collective problem’ when it is the ‘person’ with the disability? Furthermore, what constitutes a problem? And who should be given the responsibility to fix the problem? One view that emerges throughout the texts is disability as a problem of dysfunction. Function versus dysfunction requires a certain belief and understanding of normal human functioning and abnormal functioning, a distinction that is not explicitly described in most texts, but rather assumed.

Baptiste describes the dysfunction of clients: “these patients become dysfunctional in many components of their lifestyle and feel that they have abrogated control over their lives to a continuous stream of health professionals, from whom they seek care and cure” (1988, p. 3). In Baptiste’s example, she makes reference to those who experience chronic pain that interferes with function. Semantic relations, and more specifically grammatical relations, are at play between the morphemes in words such as ‘dys’ and ‘function,’ as well as ‘dis’ and ‘ability.’

Other authors make reference to the concept of dysfunction through ‘lost function.’ Miller Polgar references lost function in the following statement: “Assistive technology may be that final indicator for some people that their physical abilities are now different and will remain so for a long period of time. Technology becomes something to be feared because it is a sign of that lost function” (2006, p. 4). This statement allows the reader to understand disability as a problem of lost function and assumes that disability, in this case, is something acquired. In both Baptiste and Miller Polgar’s examples above, the problem of disability or ‘dysfunction’ resides within the individual, which has implications on the prevention, treatment, or elimination of the disability.

Further clarification of where the problem resides within a person, including the ‘type’ of disability, appears to be important in the text. Throughout the data, many authors have further
qualified disability by distinguishing between types of disability that people may have, using of some of the following concepts:

- Recently acquired disabilities (assume that disability is something that can be acquired)
- Mental health problems
- Ambulation disabilities
- Cognitive disabilities
- Physical disabilities

Regardless of the type of disability (or qualifier) described in the text, each is attributed to the person, supporting the notion that disability is an individual embodied experience.

Figure 3. The ‘Problem’ Called Disability

“...seriousness of the problem can be seen from the following facts: ...between 5% and 10% of school children suffer from mental or learning disorders” (Basset, 1975, p. 2)

"...she runs a parents class to help them handle their very small children, many of which have multiple problems" (Basset, 1975, p. 4)

“The normal relationship negotiated between professional and client casts the client in the role of the person being helped” (O’Shea, 1977, p. 3)

“We talk about the importance of ‘working with’ rather than ‘doing to’ a client in need of our assistance” (Stan, 1987, p. 3)

“These patients become dysfunctional in many components of their lifestyle and feel that they have abrogated control over their lives to a continuous stream of health professionals, from whom they seek care and cure” (Baptiste, 1988, p. 3)

“Professionals are perceived to hold the truth about how to correct disability” (Law, 1991, p. 3)

“Disability is seen as a collective problem, a problem caused by the inadequacies of the environments in which we live (Funk, 1987), not always to be ameliorated by changing the individual” (Law, 1991, p. 6)
“Occupational therapy, works with the individual to minimize disability and environmental constraints so as to enable living” (Polatajko, 1992, p. 10)

“Disability may separate individuals from the capacities that previously permitted them to experience and express spirit” (McColl, 2000, p. 5)

“What do we know about the participation of people who have mental health problems?” (Desrosiers, 2005, p. 7)

“How should we assess and influence participation of people with cognitive deficits?” (Desrosiers, 2005, p. 7)

"A young man in the early stages of rehabilitation following a spinal cord injury 'saw his wheelchair as a dreaded symbol of disability’” (Miller Polgar, 2006, p. 4)

"Our role as health care professionals will be different at different times during the clients' rehabilitation. In the early stages we need to provide much more education and information. We have knowledge that the client has not gained. It is our responsibility to provide this information in a manner that the client can comprehend and at a time that is most appropriate” (Miller Polgar, 2006, p. 6)

“Using assistive technology may be seen as giving up, as not doing all that is possible to regain lost function. AT may be that final indicator for some people that their physical abilities are now different and will remain so for a long period of time. Technology becomes something to be feared because it is a sign of that lost function” (Miller Polgar, 2006, p. 4)

4 Occupational Therapy’s Role in Disability

If disability is understood as something unwelcome that resides within the individual and needs to be fixed, the assumption is that health and rehabilitation professionals would be best suited for the challenge. Law (1991) addresses this idea in her statement: “Professionals are perceived to hold the truth about how to correct disability” (p. 3). The underlying assumptions behind Law’s comment can be examined several ways: firstly, that professionals are perceived to have enhanced knowledge (and subsequently power) as it relates to disability (a claim also supported
by Illich, 1977); secondly, that there is a truth about disability to know; and finally, that disability should be corrected. Other texts more explicitly address the role that occupational therapists or health professionals play in disability. For example:

Our role as health care professionals will be different at different times during the clients' rehabilitation. In the early stages we need to provide much more education and information. We have knowledge that the client has not gained. It is our responsibility to provide this information in a manner that the client can comprehend and at a time that is most appropriate. (Miller Polgar, 2006, p. 6)

The perception of healthcare professionals, including occupational therapists, as holders of specialized knowledge supports the hierarchical nature of the helper/helpee relationship between client and professional that was addressed in some of the texts. Fairclough describes this relational move, as it relates to the representation of social actors, as either activated (i.e., the occupational therapist actively providing services) or passivated (i.e., the client passively receiving occupational therapy services).

An examination of the images embedded in the data reveals that our representations of the professional (i.e., occupational therapist) and disability are evident not only in the written text, but also in visual representations. The first image in O’Shea (1977) depicts the client as an older white male sitting in a wheelchair with a blanket covering his legs, his hands resting together on his lap, and his head positioned against a pillow. The distinction between the client and the professional in this image is clear, despite the therapist wearing what could be considered ‘unprofessional attire’ (bandana tied in her hair, purse, and flowered bell-bottom pants). While the written text in captions above the image are helpful for determining that the clinician is a professional, the text in the caption does not identify the client/disabled person. It is assumed that no caption, text, or explanation is required to identify the disabled person, as the image appears to represent a stereotypical image and ‘universal sign of disability’—a disabled person using a wheelchair for mobility. If the caption was removed from this image, the representation of the disabled person could ‘stand alone;’ however, it is unlikely that a reader would identify the woman in the image as a professional.

O’Shea goes on to discuss the importance of conveying a professional image for occupational therapy as a means of ensuring that others understand and appreciate occupational therapy as an
essential component of healthcare delivery. The second image in O’Shea (1977, p. 6) again portrays the visual representation of a professional (occupational therapist) and a client (disabled person). The visual representation of the client in the second image is that of a younger man using forearm crutches (similar to the first image, the disabled person is using a mobility aid); however, the representation of the occupational therapist in the second image (wearing ‘professional attire’) contrasts with that in the first (wearing ‘unprofessional attire’). The contrast is obvious to a lay reader: the ‘professional’ image depicts a young, white woman with her hair tied back, wearing a button-down shirt and a sweater or shawl. She is carrying a pen in one hand and clipboard/chart in her other arm. While there are no captions or text accompanying this image, the client or disabled person is again obvious. The client is represented as a young, white male wearing a shirt, tie, and pants with a belt and using crutches.

Both of these images in O’Shea (1977) depict disability with physical markers or signs that tell the reader who the client is. The woman carrying a pen and paper to take notes conveys what O’Shea deems a subtle message to “visibly attribute legitimacy to the task at hand from the client’s perspective” (O’Shea, 1977, p. 5). The representation of professional status through such ‘subtle’ markers or signs is also evident in Polatajko (1992), where a visual image is used to depict the Enablement Model. Polatajko (1992) proposes the Enablement Model as a positive parallel to the negative vocabulary of the Disablement Model (WHO, 1980). In this image, the professional is depicted as a white male wearing dark coloured pants and shoes, with a long white lab coat and clipboard. Given the demographics of the majority of Canadian occupational therapists, the reader is likely to imagine the person in this image as a physician. This would also be aligned with the medicalization of disability in the Disablement Model that identifies three consequences of disease: impairment, disability, and handicap.

The use of words such as ‘we’ and ‘us’ versus ‘they’ and ‘them’ and the visual representations of disabled people versus professionals in the analyzed texts affirm, though not explicitly, that professionals are not disabled people, and disabled people are not professionals. Choosing to use phrases such as, “We must continue with our actions to promote engagement in valued activities and social roles from the clients’ perspective, with respect to their needs and choices” (Desrosiers, 2005, p. 8), serves an important purpose in the text. This type of language serves as a rhetorical device to signal belonging to the reader—that they are part of a community. The community is the occupational therapy community. This style of language not only fosters a
sense of belonging to a community, but it also calls for the reader to participate in some form of collective action. Desrosiers (2005) is calling for occupational therapists (the reader/audience) to promote activities and roles for clients that are important and meaningful to them. While this message is supported by underlying occupational therapy theory and the concept of client-centred practice (whereby clients are active participants or partners in goal setting and therapy interventions), the use of words such as ‘we’ and ‘our’ versus ‘clients’ and ‘their’ have the potential to enforce ‘othering.’ The concept of ‘othering,’ simply put, entails assuring the reader that ‘they’ are fundamentally different from ‘us’—that disabled people are not ‘us.’

### 4.1 Internal relations

Examination of the vocabulary within the text reveals that disability is perceived as a problem that is ‘possessed’ by people and requires the services of rehabilitation professionals to prevent, minimize, or eliminate it. Further examination of the sentence structure, format, and cohesion of the text reveals that the concept of disability is also discussed in proximity to concepts such as health, sickness, illness, and disease. By proximity, I am referring here to the closeness of the word ‘disability’ within a sentence structure to words such as ‘illness,’ ‘health,’ and ‘disease.’ This is what Fairclough (2003) refers to in texts as relations of collocation (a vocabulary/lexical relation).

The sentences that include these concepts in close proximity often do so with use of a conjunction, a word that connects parts of a sentence. By virtue of connecting concepts or clauses within a sentence, the writer is necessarily linking the two ideas for the reader. Fairclough (2003) refers to this as a paratactic semantic relation, whereby coordinating conjunctions are used between words. Figure 4 presents quotes extracted from various texts that illustrate this ‘closeness.’ Basset (1975) links the concepts of ‘sick’ or ‘disabled’ people in her statement, while Carswell-Opzoomer (1990) links the concepts of ‘illness and disability.’ Both sentences are similar, in that they include concepts of sick, illness, disabled, and disability; however, there is a slight linguistic difference. Basset (1975) uses the conjunction ‘or’ to connect the two constructs, while Carswell-Opzoomer (1990) uses the word ‘and’ to connect the two ideas. Regardless of which conjunction is used to connect the concepts of illness and disability, what I am most interested in is what the proximity of the concepts allows. I propose that the
proximity of these two words allows the reader to perceive or conceptualize the two words synonymously, jointly, or as categorically the same.

Carswell-Opzoomer (1990) also writes: “This stress was shown to have specific physiological and psychological effects leading to illness and dysfunction” (p. 4). This statement does not explicitly link the concepts of illness and disability; however, it does link the concept of illness to dysfunction. As discussed earlier, disability has been perceived in the text as a problem of dysfunction. Given this understanding of disability, a reader can infer that the meaning of the sentence would be same if the writer chose ‘illness and disability’ rather than ‘illness and dysfunction.’ The concept of dysfunction in this case can be replaced intuitively or implicitly by the idea of disability, and it remains linked to illness by virtue of proximity in the sentence structure.

As important as considering what the text allows is considering what is made impossible or disallowed in the text. If the text is seen to allow disability and illness to be linked together, then what this disallows or makes impossible is for disability and health to be linked. While this is not written explicitly in the text, it can be inferred by nature of the opposition of health and illness. Health and illness are considered binary opposites, making it impossible to be part of both health and illness categories simultaneously. If disability and illness by nature of proximity in the sentence are seen within the same category, then one can assume that both disability and illness are ‘not health.’

The notion that disability and health cannot be seen as categorically similar or simultaneously possible represents not only a separation of the two concepts (a dichotomy), but also that the concepts have been set up as binary opposites that are mutually exclusive (a dualism). When concepts are structured so that they are opposite in meaning and no overlap exists, they can be called binaries. This is consistent with the concept of dualism as described by Descartes and what Fairclough (2003) refers to as a propositional assumption, or more specifically a dualist assumption.

Figure 4. Relations of Collocation

“…occupational therapists will be able to make by virtue of the application of their skills in non-traditional ways, not only to sick or disabled persons, but to a whole process of
social reform…” (Bassett, 1975, p. 5)

“We must use our knowledge of disease and disabling conditions within a framework of social systems rather than in the confines of the treatment facility” (Stan, 1987, p. 5)

[external relations (intertextuality) as referenced from 1986: “Achieving Health for All: A framework for Health Promotion”]

“It behooves us then, to become acutely aware of the cultural meanings to our patients, of health, illness, symptoms, disabilities, in order to optimize the potential effect of our therapeutic interactions” (Baptiste, 1988, p. 3)

“The loss of a sense of control, the reduced social interaction and communication, place the person under increased stress without the power to react in a constructive way. This stress was shown to have specific physiological and psychological effects leading to illness and dysfunction” (Carswell-Opzoomer, 1990, p. 4)

“Services which promote good health, a healthy environment, adequate community and family support, which prevent illness and disability, which support people living in their home in their own way will be provided by collaborating professional and voluntary organizations” (Carswell-Opzoomer, 1990, p. 5)

“Finally, there is a wealth of literature in theology on spirit and spirituality, and a growing body on spirituality as it relates to health and disability” (McColl, 2000, p. 2)

5 Larger Social Context/Explanation

In the first part of this chapter, I have employed a relational approach to textual analysis to take apart the texts. I have used deconstruction to examine how the texts have been constructed in a way that (re)produces particular views of disability. More specifically, I have examined the words and images in detail to reveal inconsistencies in language used to refer to disability (i.e., ‘the disabled,’ ‘disabled people,’ ‘people with disabilities’) and to those who receive occupational therapy services (i.e., ‘patient,’ ‘consumer,’ ‘client’). I have also focused on the ways that disability is positioned in the text (i.e., disability as a problem/dysfunction), as well as
the assumed relationship between disability and illness based on their proximity within the sentence structure (relations of collocation). In the remainder of this chapter, I consider how the linguistic features of the text are situated within a broader social-cultural/political context.

5.1 Interpretation and explanation

Critical discourse analysis is “based upon the assumption that language is an irreducible part of social life, dialectically interconnected with other elements of social life” (Fairclough, 2003, p. 2). As such, certain language choices and words are made possible to the authors through particular socio-political contexts. Following Fairclough’s three dimensional method of discourse analysis, I now focus on processing analysis (interpretation) and social analysis (explanation). I do so by highlighting particular socio-political contexts that frame the data and make particular views of disability and the world possible to the reader.

Fairclough (1992, 2003) asserts that language and text must be read within the context of broader social and political contexts. As such, it is equally important to question the extent to which the choices of language throughout the texts are politically driven and socially contextualized. The consideration of language used to describe disability and those who are ‘disabled’ is not a new phenomenon and has in the past several decades gained considerable attention, both socially and politically. Person-first language refers to a way of speaking and (re)presenting disability, by suggesting that people with disabilities are not defined or identified by their disability; rather, they are people first—people who happen ‘to have’ a disability. The phrase ‘people with disabilities’ has been used since the 1970s; however, it gained significant popularity following the proclamation of the International Year of Disabled Persons (IYDP) by the United Nations in 1981 (Titchkosky, 2001). The phrase ‘person with a disability’ also appears to be a response to the strong opposition of using ‘mass nouns’ to describe people, such as ‘the disabled’ or ‘the handicapped.’

I have already discussed the history of occupational therapy and its relationship with biomedicine in detail in Chapter 1; however, I would be remiss not to consider the moves that occupational therapy has made through time, as well as the alliance that has formed between medicine and rehabilitation, as important contextual factors that influence language and thought in the texts. Judith Friedland’s article, published in 1997, chronicles what she calls an “awkward alliance” (p. 373) between occupational therapy and rehabilitation. She goes on to describe a shift in focus for
occupational therapy, from occupation as it relates to health to occupation as a means of enhancing medical outcomes. The shift that Friedland describes is consistent with others who describe the philosophical struggle to move occupational therapy away from its roots and origins in an effort to align the profession more closely with medical values and philosophy (Friedland, 1997; 2011).

In line with the alignment of occupational therapy with rehabilitation and medicine, occupational therapy has also moved towards more specialization. Occupational therapists often focus their clinical work and hone their clinical skills in specialty areas, including: orthopaedics, mental health, paediatrics, and hand therapy. Specialization or focus on specific areas of clinical practice allows for the qualifying of ‘types’ of disability. Both require a breaking of the body into multiple ‘parts.’ For example, one of the most commonly debated dichotomies in healthcare is the mind/body dichotomy. While many of the texts analyzed in the study affirm the philosophical value of a holistic approach in occupational therapy and how occupational therapists view the whole person, there continues to be a push towards establishing clinical expertise in mental health or physical health. Furthermore, categories of disability are described in the text as ‘cognitive disabilities,’ ‘physical disabilities.’ or ‘mental health problems.’

Equally important to consider in terms of Fairclough’s processing analysis and social analysis is the socio-political influence that the World Health Organization (WHO) has had on the profession of occupational therapy (WHO, 2008). It is necessary to consider the evolution of conceptual thinking as evidenced by cultural artifacts—such as the International Classification of Disease; the International Classification of Impairments, Disabilities, and Handicaps (ICIDH) (WHO, 1980); and the International Classification of Functioning, Disability, and Health (ICF) (WHO, 2001)—and the impact they have had on the texts that I examine. Given occupational therapy’s alignment with medicine over the years, it is not surprising that the written language in the texts make reference to key terms and artifacts of the WHO and assumes certain knowledge by the reader of those artifacts. References throughout the texts are historically situated, evolving as the WHO produced its iterations of the ICIDH. In other words, the WHO has made possible specific language by setting a certain context that provides the space for disability to be (re)produced in specific ways. An example in the texts of shifting language impacted by the WHO is that of ‘impairment,’ ‘disability,’ ‘handicap,’ ‘activity limitations,’ and ‘participation restrictions’ based on a ‘deficit model.’ These words/phrases are used throughout the texts,
changing as the WHO shifted what it deemed appropriate and relevant language in their evolution of classification systems/models.

In addition to the influences of the WHO on the profession of occupational therapy in Canada, national consensus guidelines published by the Canadian Association of Occupational Therapists (1991, 1993, 1997) and the Department of National Health and Welfare (1983, 1986, 1987) also played an important role (Canadian Association of Occupational Therapists, 1997). The landmark document, *Enabling Occupation: An Occupational Therapy Perspective*, first published in 1997, is considered a leadership document, offering a client-centred perspective that establishes ‘enablement’ as the focus for client-centred practice (Canadian Association of Occupational Therapists, 1997). Swedlove and Brown (1997) provide ideas for using the guidelines established in *Enabling Occupation: An Occupational Therapy Perspective* that include: educating occupational therapists, guiding practice, research and policy development, and advocating with and for clients. This seminal text (cultural artifact) provides the context within which many of the Muriel Driver Lectureships were delivered in Canada.

The health/illness dualism that I have proposed based on the proximity of language, or relations of collocation (e.g., disability and illness), in the data can be considered as part of the socio-cultural context as well. The practice of thinking about the world in categories of binary opposites is common in the Western world (Western ontology) and an important concept consistent with structuralism. In structuralism, the categorization of concepts into binary opposites is a necessary precursor to understanding and organizing language and thought. However, this type of dualistic thinking is not a universal way of seeing the world, and Eastern philosophies are founded more on interconnectedness (Iwama, 2003; Hammell, 2006).

So what does this dualistic way of seeing the world in Western thought allow for in the texts? This type of dualistic thinking allows for the texts to distinguish between ‘normal’ and ‘abnormal,’ ‘functional’ and ‘dysfunctional,’ and ‘disabled’ and ‘not disabled.’ These artificial categories are set up throughout the texts as binary opposites—which is not surprising, given that the texts represent broader social and cultural contexts, within which dualistic thinking is broadly accepted.

I now consider one final socio-political context as part of my analysis of the texts. The social context within which occupational therapy is situated is one of limited healthcare resources.
Based on economic restrictions, the Canadian healthcare system has long struggled with issues of supply/demand of healthcare services. In this context, service providers have been pushed to objectively measure the impact of their interventions. The use of tools (e.g., assessment tools, outcome measurement tools, etc.) to ‘objectively’ measure data and statistically demonstrate positive outcomes is required to support the process of securing funding for continued services. For example, if positive outcomes are not demonstrated through the use of ‘validated’ and ‘standardized’ tools, services are at risk of being eliminated. Occupational therapists working in the healthcare field are required to participate in the measurement ‘game’ in order to ensure they maintain a position in healthcare. It is reasonable to assume that this game sets the context for occupational therapists to define disability objectively, and as problematic, in order to demonstrate the effectiveness of occupational therapy interventions on ‘fixing’ disability. The competitive nature of ensuring a position in the healthcare system also helps to explain why the concept of professionalism has been considered so important in the data. The profession of occupational therapy has been required to establish its credibility and legitimacy in a medically oriented healthcare system in order to ensure the viability of the profession.

6 Summary of Chapter

In summary, I started this chapter with a close examination of the texts, including a review of the vocabulary and structure of sentences as they relate to how disability has been constructed. Through textual analysis of the inconsistencies in terminology/vocabulary, I have drawn out the internal and external relations as described by Fairclough (2003). The inconsistencies in word choices demonstrate that occupational therapy has struggled with language throughout the texts. Based on my interpretation of value assumptions (Fairclough, 2003), the concept of disability has been constructed as a problem in the texts, and more specifically as ‘dysfunction.’ Finally, I have proposed a disability/health dualism based on observed sentence structure within the data, which is considered a higher-level semantic relation (Fairclough, 2003). I have explained all of these observations at the level of interpretation and explanation by highlighting various important socio-political contexts, including occupational therapy’s alignment with medicine and the impact that this alignment has had on occupational therapy language. Lastly, I have described the challenges that occupational therapists in the Canadian healthcare system have faced—and the impact this may have had on the need for occupational therapy professionals to establish their legitimacy and credibility within the system.
Chapter 4
What Is the Meaning of Disability?

1 Introduction

In Chapter 3, I examined the vocabulary and visual images in the texts in detail in order to deconstruct ‘what disability is.’ In this Chapter, I build on the understanding of what disability is, and I examine what disability has been revealed to be in the data—that is, how disability has come to exist in the profession of occupational therapy and what meaning has been attached to disability. I discuss the underlying or unspoken assumptions that have come to give disability meaning in the texts. By deconstructing words and meaning in the texts, I highlight how certain ways of thinking are made possible, while others are made impossible. This is what Foucault (1994, p. xxii) refers to as the “conditions of possibility.” In my reading of the texts, I do not ‘assume’ any intentionality by the authors to convey particular messages regarding the meaning of disability; rather, I focus on what has been made possible through the text. I not only focus on the words that are used to describe the meaning of disability, I also focus more extensively on what the assumptions ‘allow’ and ‘disallow’ by ‘reading between the lines.’ I make inferences about concepts by connecting ideas that allow disability to be present or absent.

2 Cause and Effect

In Chapter 3, I presented the idea that disability has been constructed in the text as a ‘thing’ that is problematic. The term disability is used alongside other terms, such as illness and dysfunction (relations of correlation), when describing the people who possess the disability. In this Chapter, I focus on the meaning that has been ascribed to disability, uncovering some of the hidden assumptions associated with living with a disability.

To begin, I now consider the concept of causality or causation. Taking a relational approach to the text, Fairclough would refer to this as a type of semantic relation, and more specifically a causal relation that is paradigmatic (i.e., not necessarily present in the text, but understood). Is disability caused by something (i.e., a condition)? Does disability cause something (i.e., a condition)? Has disability come to mean something that causes something else? Or is it the effect of something else that has caused the disability?
The philosophical consideration of causality has long been documented as a subject of interest in many disciplines in Western thought, and it remains a topic of interest in contemporary philosophical discussion. The ‘cause’ and ‘effect’ conversation dates back to Aristotle, and it refers to the relationship between an event (the cause) and a second event (the effect), whereby the second event is understood to be a result/consequence of the first event. Cause and effect is further emphasized in a logical positivist perspective. For example, Sally removes her hand quickly after placing it on a hot stove and burning herself. The heat causes Sally to remove her hand quickly (the effect).

2.1 Causal relations

In my analysis of the text, I have noted the discursive practice of relating to disability as ‘caused by a condition’ or of relating to disability as ‘a condition that causes’ an effect on the person or their occupational ‘functioning’ (see Figure 5). Language that signals this causal relationship includes: ‘leads to,’ ‘is the cause of,’ or ‘can create.’ While this distinction in vocabulary (i.e., disability as cause versus effect) may seem like a minor differentiation, it has broader implications for how meaning is ascribed to the phenomenon of disability.

If disability is conceived as a condition in itself that may result in some other outcome, and the condition of disability is thought to be some problematic ‘thing’ that is possessed by an individual, it is possible to understand how and why occupational therapy treatment should be focused on remediation at the individual level. What comes to the foreground is the perception that disability is an individually embodied problematic condition to be eradicated (in this type of language, disability is the condition). When perceived as the ‘cause,’ disability has the potential to result in an effect. This relationship can also be labeled a causal nexus, which is a link between probable causes and resulting effects.

An alternative discursive practice present in the texts is that of portraying disability as the result or effect of another condition. What moves to the background in this alternative perspective is the idea that disability is ‘the’ condition, and what comes to the foreground is that disability is ‘caused by’ another condition. For example, Stan (1987) refers to other conditions that can result in disability. She states: “disease, stress and other factors can create occupational dysfunction which is addressed by the occupational therapy process” (p. 3; disability is assumed to share
meaning with occupational dysfunction, as per Chapter 3). Other texts have presented disability as caused by illness, injury, chronic pain, and inappropriate environments (WHO, 2001).

When the meaning of disability shifts to be conceived of as a result of another condition (i.e., an effect), it allows for alternate interpretations of what constitutes appropriate interventions. An example of this is present in Law’s (1991) Muriel Driver Lectureship: “It is helpful to think of environments in terms of environmental risk. For occupational therapy, this means the risk that certain environments will lead to dysfunction in occupation” (p. 6). If disability has come to mean dysfunction (see Chapter 3), then this statement allows disability to be seen as the effect of environmental causes. In this case, the environment is what causes disability. As such, Law states: “If environments foster dependency and poor resolution to the problems of disability, then solutions will exist predominantly in intervention aimed at the modification of the environment” (p. 6).

Occupational therapists are expected to demonstrate ‘problem-solving’ skills in their daily roles. Whether working in clinical or non-clinical roles, occupational therapists often look for ‘root causes’ when faced with a problem in need of solution. If disability is seen as a result/outcome that is ‘caused by another condition,’ then the intervention would necessarily address the ‘symptom/result’ (disability), as well as the root cause that is producing the disability (i.e. pain, illness, injury).

Figure 5. Disability: Cause or Effect?

“…human beings have an occupational nature and require participation in work, play and daily living tasks; that disease, stress and other factors can create occupational dysfunction which is addressed by the occupational therapy process…” (Stan, 1987, p. 3)

“Chronic pain is a clinical entity characterized by pain of longer than six months duration, which does not respond to traditional treatment methods, and is the cause of lifestyle dysfunction” (Baptiste, 1988, p. 3)

“Thirdly, disability often leads to occupational dysfunction” (Law, 1991, p. 4)

“It is helpful to think of environments in terms of environmental risk. For occupational therapy,
this means the risk that certain environments will lead to dysfunction in occupation” (Law, 1991, p. 6).

“If environments foster dependency and poor resolution to the problems of disability, then solutions will exist predominantly in intervention aimed at the modification of the environment” (Law, 1991, p. 6)“In Quebec, traditionally there are no well-organized occupational therapy services for people with chronic disabling conditions such as those who have had a stroke” (Desrosiers, 2005, p. 6)

3 External Relations

Further exploring the ways that disability has been ascribed meaning in the text, I now consider ‘possibilities not spoken’ by uncovering the hidden assumptions in text. In order to reveal the meanings implicit in the text, I draw on logical implications as referenced in linguistic pragmatics. In the field of linguistic pragmatics, implicit meanings that can logically be inferred by features in texts are termed ‘presuppositions.’

3.1 Disability, health, and happiness

Disability as discussed in Chapter 3 appears to be linked to categories of illness or disease. The texts allows for disability to be linked to these concepts by their closeness or proximity within sentence structures, sometimes separated by only one word (‘and,’ ‘or’). The category of illness and disease (if grouped together) is perceived as ‘not health.’ Health and illness can be considered a dualism in Western thought (see Chapter 3), and these concepts are often set up as binary opposites that are mutually exclusive. This prohibits a person from being categorized in both ‘health’ and ‘illness’ categories. One must either be classified as healthy or ill. When disability is constructed in the same category as illness or disease, it too becomes a binary opposite of health. This allows disability (like illness or disease) to be considered ‘not health.’ Of course, if disability is seen this way, it could make being a healthy disabled person impossible (i.e., a healthy blind person or a healthy woman with an amputation). Figure 6 presents a schematic representation of the logical implications.
Figure 6. Schematic of Logical Implications: Disability/Illness

IF

Illness does not equal health

AND

Disability = illness

THEN

Disability does not equal health

The idea that disability and health are binaries is neither written in the texts, nor do I assume it to be the intention of any of the writers. However, the texts allow for this to be a possibility through proximity of language and inference. Assuming that health is the opposite of illness/disability, I now further explore the concept of health to uncover what disability ‘is not.’ The WHO (2003) has long defined health as: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” This definition has not been amended since 1948, and there have been calls for the WHO to reconsider it (Sarracci, 1997; Dolfman, 1973). Of particular concern is the statement “complete state of mental well-being,” which has been likened to the concept of happiness. If the definition of health includes the concept of happiness, then happiness becomes an essential characteristic of health. Following similar logic to what I have proposed regarding health and disability, the same can be inferred with health and happiness. If happiness is an essential characteristic of health, then it becomes impossible for someone to be both unhappy and healthy at the same time. Following this logic, anyone who is unhappy could be considered unhealthy as well (or ‘sick’). As a result, medical treatments and interventions would be merited for those who are unhappy.

The significance of the relationship between health and happiness is obvious when considering the health/disability dualism. If happiness is an essential characteristic of health, and disability is considered ‘not health,’ then the concepts of disability and happiness also become incompatible. If disability is considered ‘not health’ (ill-health), then disability would also be considered ‘not happy’ (unhappy). Of course, if health and happiness are seen this way, it would make being a
happy disabled person impossible (i.e., a happy blind person or a happy woman with an amputation). It seems far-fetched and perhaps ludicrous to imagine that disabled people could be constructed as both unhealthy and unhappy; however, the text allows for this possibility. For a schematic representation, see Figure 7.

Figure 7. Schematic of Logical Implications: Disability/Happiness

<table>
<thead>
<tr>
<th>IF</th>
<th>Health = happiness (happiness is an essential component of health)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AND</td>
<td>Disability does not equal health</td>
</tr>
<tr>
<td>THEN</td>
<td>Disability does not equal happiness</td>
</tr>
</tbody>
</table>

I will now consider the discursive practice of relating disability with the concepts of ‘flow,’ ‘occupation,’ and ‘quality of life’.

3.2 Disability, occupation, flow, and quality of life

3.2.1 Occupation

Occupational therapists have been concerned with the concept of ‘occupation’ since the inception of the profession. In fact, over time, occupational therapy professionals have debated the concept of occupation as a term that is poorly understood outside of the profession. In Canadian occupational therapy, the term occupation has come to mean the activities that people want to do or need to do. These occupations that occupy our time are believed to describe who we are and how we feel about ourselves (Canadian Association of Occupational Therapists, 2015a). The Canadian Occupational Therapy Association (2015b) has published Occupational Therapy Values and Beliefs, which states that occupational therapists believe (among other things) that occupation: gives meaning to life, is an important determinant of health, shapes and is shaped by environment, and has therapeutic potential. In occupational therapy, occupations are often classified under the categories of: self-care, productivity, and leisure.
3.2.2 Flow

Occupation is a core concept in occupational therapy. Related to the idea of engagement in an occupation is a concept termed by Csikszentmihalyi (1975, 1990): ‘flow.’ The concept of flow refers to a psychological state that is experienced when one is totally immersed in an occupation (Csikszentmihalyi, 1975, 1990). Flow is commonly described in occupational therapy as when engaging in an activity (or occupation), you ‘lose track of time.’ The flow channel as described by Csikszentmihalyi (1975) represents a balance between a person’s perceived skills and abilities to perform an activity with the demands of the activity itself. This balance is considered essential to experiencing flow. In occupational therapy, flow is considered an optimal experience and one that represents an appropriate match between personal skills and occupational demands (Emerson, 1998). Flow is said to be dynamic, in that changes in demands, skills, or occupations will result in changes in flow. A person is said to experience anxiety when the demands of the activity outweigh personal skill/ability—and boredom if the activity is not deemed challenging enough (Csikszentmihalyi, 1990). Occupational therapy interventions can thus be geared towards ensuring that people have the appropriate skills/abilities and modifying activities to an appropriate level. This balance is often referred to in occupational therapy as the ‘just right challenge.’

3.2.3 Quality of life

‘Quality of life’ appears in the texts as another important concept in occupational therapy. The WHO defines the concept of quality of life as an “individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHO, 1997). On the one hand, quality of life is deemed essential to experiencing health; on the other, it is also affected by a person’s health. As a concept, quality of life is assumed to be an optimal subjective experience that as humans we strive to achieve. Measurement tools have been created to ‘objectively’ measure the ‘subjective’ experience of quality of life. Measurement of quality of life will be discussed in more detail in this chapter. Quality of life has been described as the link between health promotion and rehabilitation (Renwick, Brown, & Nagler, 1996). The relationship between quality of life and health is important when examining how disability has come to have meaning in occupational therapy.
3.2.4 Intersection between occupation, flow, quality of life, and disability

The concepts of occupation, flow, and quality of life intersect with the phenomenon of disability in the texts. A review of the language throughout the texts combined with inference (‘reading between the lines’) allows for the appearance of disability when concepts such as flow and quality of life are discussed. Understanding that flow is achieved when there is an optimal balance between a person’s skills/abilities and the demands of the activity, one can reasonably assume that flow is impacted by the idea of disability. If disabled people are perceived to have fewer or less developed skills and abilities to ‘do’ activities, then one can assume that they are less likely to achieve flow in their everyday lives. This would be the result of either an inability to meet the demands of activities, or an inability to structure activities to achieve an appropriate balance. Taken directly from a text, we can see how a limited amount of time in activities that promote flow is seen to impact quality of life: “Time spent in flow activities during a person’s daily life experience correlates significantly with overall quality of life” (Law, 1991, p. 5). Does the concept of flow allow the reader to infer that disabled people are less likely to experience flow activities in their daily life? And given an understanding that less time in flow is correlated with decreased quality of life, does this allow for the perception that disability is linked to decreased quality of life as a result of decreased flow experiences? While the texts do not explicitly link disability with flow or quality of life, a critical examination of the texts allows for disability to appear ‘between the lines.’ When disability makes an appearance in this way, it can be understood as a barrier to achieving optimal flow, leading to decreased quality of life and finally resulting in decreased health. Figures 8 and 9 represent the inference/logic applied when critically examining the unspoken assumptions regarding concepts of flow and quality of life in the text.

Figure 8. Schematic of Logical Implications: Disability/Flow

<table>
<thead>
<tr>
<th>IF</th>
</tr>
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<tbody>
<tr>
<td>Flow = skills and abilities / occupational demands</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability = decreased skills and abilities</td>
</tr>
</tbody>
</table>
THEN

Disability = decreased opportunity for ‘flow’

Figure 9. Schematic of Logical Implications: Flow/Quality of Life

IF

Decreased flow activities = decreased quality of life

AND

Disability = decreased flow activities

THEN

Disability = decreased quality of life

Another intersection that I will now discuss is the relationship between satisfaction with participation, quality of life, and long-term health. It is said in one text: “Satisfaction with participation is more positively related to quality of life than participation itself” (Desrosiers, 2005, p. 5). Desrosiers goes on to reference Noreau and Fougéryrollas (2000): “Therefore, this personal subjective judgement has to be considered as a determinant of quality of life which is inherent to long-term health” (2005, p. 5). When disability is imposed on this series of statements, it allows disability to appear once again to be linked to quality of life and health (in this case long-term health). The possibility is that disability may be perceived as causing less satisfaction in participation, and therefore a decreased quality of life resulting in poorer long-term health. Given that participation in occupation is central to occupational therapy intervention, it is important to consider how the core concepts intersect with disability, both explicitly and implicitly as revealed through inference.

3.3 Value assumptions

3.3.1 Disability as a life with limits

Texts allow for examination, not only of how a concept like disability is defined, but also of the meaning that is attached to the phenomenon. I now discuss how disability is ascribed meaning in
occupational therapy texts as it relates to the practice of conceiving of disability as a life with limits or as a life with possibilities. Figures 10 reveals several relevant sections of the text.

Figure 10. Disability as Life with Limits

“Occupational therapy empowers people to achieve their potential and live a meaningful life. It provides the guidance and instruments for clients to attain their goals and objectives. It sustains an environment in which the client can experience the same joys and miseries of life and can experience similar feelings of achievement, value and self-worth as do all of us” (Carswell-Opzoomer, 1990, p. 6)

“Experiences in a wide variety of supportive environments are necessary for optimal living. People with disabilities are not able to achieve these experiences because the environments in which they live have many constraints” (Law, 1991, p. 8)

“Nancy B. demonstrated by dying that the capacity for doing is as essential to living as the capacity for breathing” (Polatajko, 1992, p. 2)

“The classic symbol of handicap (lower left corner), is that of a person with an ambulation disability in a box. The box is considered to symbolize the constraints placed on the individual with disabilities. Occupational therapy, works with the individual to minimize disability and environmental constraints (middle drawing) so as to enable living (right drawing)” (Polatajko, 1992, p. 10)

“One way that spirit was experienced by our participants in relation to their disability was a reminder of their physical vulnerability and mortality” (McColl, 2000, p. 5)

“Often disability brings individuals even closer either to death or to the idea of death” (McColl, 2000, p. 5)

“Finally, it has been suggested that events like the onset of a disability arouse doubts in our assumptions about the essential goodness of the world” (McColl, 2000, p. 5)

“Referring to both our interviews with people with disabilities and to the literature, it seems that there are at least four ways in which individuals experience spirit when disability overtakes their
world” (McColl, 2000, p. 5)

“Assistive technology viewed in this manner is seen as a symbol of disability; recognition that life has changed because of trauma or chronic condition. It reflects this young man’s inability to see how he will be able to regain his roles in society and engage with his community” (Miller Polgar, 2006, p. 4)

When disability is perceived as a problem in need of remedying, it becomes possible to imagine disability as undesirable. However, the meaning of disability as a life with limits is illuminated through vocabulary in the text. For example, Miller Polgar discusses the relationship between assistive technology and the symbol of disability:

Assistive technology viewed in this manner is seen as a symbol of disability; recognition that life has changed because of trauma or chronic condition. It reflects this young man’s inability to see how he will be able to regain his roles in society and engage with his community. (Miller Polgar, 2006, p. 4)

In this example and through the text, disability is again perceived as a ‘thing’ that is problematic. Through the words, “recognition that life has changed because of trauma or chronic condition,” disability is seen as an effect that has been caused by trauma or other chronic condition. The resulting disability has now changed life in some way that makes it unimaginable how a young man will regain his roles or engage with his community.

In Polatajko’s 1992 text, an image portraying the “classic symbol of handicap” with “constraints placed on the individual” (p. 10) allows for disability to be perceived as a life with limits. The “classic symbol of handicap” visually allows for an almost ‘universal’ understanding of the constraints or limits that having a disability places on the individual. McColl’s (2000) text also refers to the “overtaking” nature of disability on people’s lives. Through the text, the idea of disability as a life with limits comes to the foreground, while the idea that disability could instead represent a life with possibilities is driven to the background. Seeing disability as a life with limits allows for an awareness of certain freedoms that are experienced by those who are not disabled (Titchkosky, 2012). Imagining this freedom as limited or constrained in some way allows for the idea of living with a disability to become unimaginable. If not unimaginable, it allows the meaning of living with a disability to become something of a tragic nature.
The thought that living with a disability can bring “individuals even closer either to death or the idea of death” (McColl, 2005, p. 5) also illuminates the limiting nature of disability: limiting in terms of living and life. The ideas of living, living a meaningful life, or living an optimal life are also evident in the texts. In Polatajko’s (1992) Muriel Driver Lecture, a case study of Nancy B. is described: “Nancy B. demonstrated by dying that the capacity for doing is as essential to living as the capacity for breathing” (Polatajko, 1992, p. 2). While these two examples are unrelated in topic area, they each bring the concept of disability close to the concept of death in their use of vocabulary. In the case of Nancy B., the words “essential to living” signal to the reader that in order to ‘live,’ one must have the capacity to ‘do.’ Occupational therapy is seen as the intermediate that enables people to ‘live’ by enhancing their capacity to ‘do.’ Not only is occupational therapy made to enable living in the text, but it is also made to enable meaningful and optimal lives.

I more closely examine the following excerpt as it relates to the meaning of living with a disability:

Occupational therapy empowers people to achieve their potential and live a meaningful life. It provides the guidance and instruments for clients to attain their goals and objectives. It sustains an environment in which the client can experience the same joys and miseries of life and can experience similar feelings of achievement, value and self-worth as do all of us. (Carswell-Opzoomer, 1990, p. 6)

Through the text, it is possible to view disabled people as requiring occupational therapy in order to live meaningful lives. Of course, the text does not suggest that disabled people lead lives that are meaningless, but the possibility of this interpretation lives in the vocabulary. The text connects ideas of value and self-worth (in other words, meaning) to the lives of disabled people. It suggests that feelings of achievement, value, and self-worth are ‘normal’ states of living for ‘all of us,’ but that work needs to be done to sustain these feelings for ‘clients.’ The use of ‘us and them’ language is described in Chapter 3.

An examination of data extracted from Law’s 1991 Muriel Driver further describes the concept of optimal living: “Experiences in a wide variety of supportive environments are necessary for optimal living. People with disabilities are not able to achieve these experiences because the environments in which they live have many constraints” (Law, 1991, p. 8). This text suggests
that experiences in supportive environments are essential to optimal living. It also suggests that experiences in a wide variety of supportive environments are not possible for disabled people, due to constraints in the environments. The text allows disability to be conceived of as something outside of the person (i.e., it is caused by disabling environments), and it therefore allows occupational therapy treatment to be focused on the environment rather than the person. While the text does not explicitly address the meaning of living with a disability, it allows for the possibility that living with a disability might be sub-optimal. Figure 11 schematically demonstrates the logic that, when applied to the text, allows for disability to have this meaning. This draws on logical implications or presuppositions as described in the field of linguistic pragmatics. The examples of texts described above (Figure 10) allow for disability to mean living a life with limits: a life with limits on the freedoms that non-disabled people experience. The freedoms that are experienced by non-disabled people are only illuminated through exposing the possible limitations (i.e., becoming disabled means living a life with limitations on the freedoms once experienced). Living a life with disability becomes conceivable only as unimaginable.

Figure 11. Schematic of Logical Implications: Disability/Sub-Optimal Living

| IF | Experiences in a wide variety of supportive environments = optimal living |
| AND | Disability = not able to achieve experiences in a wide variety of supportive environments |
| THEN | Disability = sub-optimal living |

### 3.3.2 Disability as a life with possibilities

I have demonstrated the meaning of life with a disability as a life with limits through an examination of the text and inference (logical implications). I now explore a perspective that makes an alternate view of the meaning of life with a disability possible (see Figure 12). While
imagining life with a disability as a life with limits is a dominant discursive practice in the texts, it is possible to see how disability allows for possibilities as well. McColl (2000) refers to disability as an “existential antecedent to spiritual experiences” (p. 9). The word “antecedent” signals to the reader that disability is what existed before or preceded the spiritual experiences. It is possible in this statement to understand disability as the ‘cause’ rather than the ‘effect’ and to imagine disability as offering an opportunity that otherwise would not have been possible (i.e., spiritual experiences). When it is ascribed this meaning, disability has the potential to allow for a “sense of purpose” in life and spiritual experiences.

Living a life with a disability can be imaginable if it comes to mean that new possibilities are made a reality through living with a disability. While this is not the dominant discourse in the texts, it is an alternative that is offered through McColl’s discussion of spirituality. The statement, “…one therapist told me of a client who made a ritual of honouring the new self by burying something that had been a symbol of the pre-disability self” (McColl, 2000, p. 9), refers to two different ‘selves.’ A ‘pre-disability self’ and a ‘new self’ signal to the reader that a ‘new self’ is made possible only through disability. When framed as a ‘new self,’ the meaning of life with a disability remains imaginable. This provides an alternative to the perception that disability is simply a life with limits that is unimaginable.

Figure 12. Disability as Life with Possibilities

“We know that there are some activities that are more likely to invoke the presence of spirit. Activities that are antecedents to spiritual experience can be categorized as either existential, meditative or creative. We have already talked about existential antecedents to spiritual experiences, specifically the disability itself” (McColl, 2000, p. 9)

“Some participants stated that they did not have a purpose before their injury, but now did as a result of their disability…” (McColl, 2000, p.6)

“…one therapist told me of a client who had made a ritual of honouring the new self by burying something that had been a symbol of the pre-disability self” (McColl, 2000, p. 9)
4 Larger Social Context/Explanation

In the first part of this chapter, I have used a deconstructive approach to examine occupational therapy writings at the level of the text. I have used concepts in logic, such as inference, to examine the underlying assumptions or interpretations that become possible only through ‘reading between the lines.’ In this part of the chapter, I examine the larger social and political contexts in healthcare that have allowed for interpretations of the meaning of disability to be conceived in occupational therapy. What impact (if any) does the discipline of medicine have on the meaning of disability in occupational therapy? What concepts or ideas emerging from the World Health Organization provide the context for allowing disability to be understood as a life with limits?

Medicine has long been criticized for conceiving of the body in a reductionist way (Oliver, 1983; Oliver, 2004; Shakespeare, 2013). That is to say, the body can be thought of as ‘parts’ that come together to make a person. The process of separating the body into necessary parts that can be examined independently of one another allows for specific understandings of the whole body. A disabled body then becomes a body with ‘missing’ or ‘dysfunctional’ parts. Conceiving of disability in this way makes imagining a life with disability as a life with limits or limitations on ‘parts’ of the body. As a result, it makes the idea of living with a disability seem tragic or unimaginable.

A landmark legal case in Canada that may best explicate the concept of disability as a ‘life with limits’ is that of Robert Latimer. Mr. Latimer was charged and convicted of murdering his daughter, Tracy Latimer, in October 1993 (Council of Canadians with Disabilities, 2013). The defense he offered—that he wanted to end his twelve-year-old daughter’s pain and suffering caused by severe cerebral palsy—did not sway the Canadian courts, which convicted him of second-degree murder. The Latimer case received National media coverage and was widely known in contemporary society throughout the 1990s and early 2000s. Topics such as euthanasia, mercy killing, and compassionate homicide became grounds for debate between the medical community and disability rights advocates, who felt that leniency in the Latimer case would be used to further justify murdering disabled people as a means of relieving them from their ‘suffering.’ Disability rights advocate, Catherine Frazee, suggested that: “the principle message has to be one affirming our humanity – that it cannot be disregarded, diminished,
“devalued by persons who have no insight into disability experience” (Council of Canadians with Disabilities, 2013). Frazee went on to describe the “collective mythology” that exists in Canadian society, that people with disabilities must be living a tragic life that is marked by deprivation and suffering. The Latimer case and the argument supporting compassionate homicide are only made possible when one imagines living with a disability as a life with limits, or a life not worth living.

Medicine as a discipline requires taking a ‘problem-based’ and ‘problem-solving’ approach when faced with determining the causes of illness. Illness and disease appear to be universally constructed as problematic and undesirable. As such, identifying the causes and effects of illness and disease becomes essential to ‘curing’ the underlying pathology. Determining the difference between the symptoms of a disease (the effect) and the pathology of a disease (the cause) are central to the field of medicine. Physicians must not only determine and treat root causes of illness/disease, but they must also consider alleviating undesirable symptoms as well. This deep-rooted dependency on considering causes/effects has implications for how the body is reconstructed in other health professions. More specifically, the healthcare environment has set up a context in which health professionals may speak about disability in terms that reflect disability as a condition itself (a cause) versus something that is caused by another condition (an effect).

The ability to reduce the body into ‘parts’ (body parts, organs, cellular components) has allowed for incredible discoveries to eliminate unwanted pathogens. Breaking the body into smaller parts has allowed for specific specializations within the field of medicine and healthcare more broadly. Specialists in particular fields have developed an expertise in specific organs, systems, body parts, or illnesses (e.g., cardiologists focusing exclusively on the heart and heart function, a hand therapist focusing on the hand and hand functioning, and an oncologist focusing on cancers that invade the body). There is no doubt that the magnitude of these biomedical advancements has changed our understanding of the body and the illnesses and diseases that impact lives. However, when the body becomes something that can be broken up into smaller parts, it allows for life with a disability to become unimaginable. The disabled person is no longer naturally viewed as a ‘whole’ but as a series of parts that are or have become dysfunctional. The socio-political contexts of medicine and the healthcare industry allow disability to be conceived in this way. As a health profession that is often situated in the field of rehabilitation, occupational therapy has been assimilated into medical contexts and environments.
Occupational therapy is also situated within the health disciplines that are historically referred to as ‘allied health’ disciplines to indicate a specific relationship with medicine. As such, it has necessarily been influenced by the broader concepts, models, and instruments that have emerged from the World Health Organization. This alliance seems fitting, given that the link between occupational therapy and health is clearly stated in the values and beliefs described by the Canadian Association of Occupational Therapists (discussed earlier in this chapter). The intersectionality between concepts such as disability and illness, health and happiness, and quality of life and health are all made possible through the socio-political contexts of healthcare.

The dominant ways of knowing about the body in a field that values a reductionist perspective to uncovering life-altering discoveries are based on empirical data. The concepts of ‘evidence-based medicine,’ followed by ‘evidence-based practice,’ and more recently ‘evidence-informed practice’ have become important for all health professions. The dominant ways of constructing knowledge/evidence about the body come through objective measurement and statistical analysis. For example, I now consider two important measures that have emerged and been widely adopted with support from the WHO. Both measures are used to quantify the ‘burden of disease,’ and they have broad implications for how disability is re-constructed in occupational therapy.

The ‘burden of disease’ is measured using a variety of measurement tools addressing the cost, mortality, and morbidity of living with a specific disease. These ‘population health’ and measurement tools include, but are not limited to, the Disability-Adjusted Life Year (DALY) and the Quality-Adjusted Life Year (QALY) (Sassi, 2006). The DALY is a highly recognized, widely adopted measurement tool that uses the unit of ‘time’ to measure the ‘burden of disease.’ One DALY is often considered one lost year of ‘healthy life.’ The following formula is used to calculate DALY:

\[
\text{DALY} = \text{YLL} + \text{YLD}
\]

\[(\text{YLL} = \text{years of life lost due to premature mortality}; \text{YLD} = \text{years lived with a disability})\]

The sum of DALYs is calculated across populations, within and between nations, in order to identify ‘gaps’ in the health status of a particular population compared to an ‘ideal health situation.’ An ideal health situation is assumed to be one in which the population lives to
expected ages without disease and disability. Disability ‘weights’ are applied in sophisticated formulae, essentially placing numerical values on a scale of 0-1. A score of 0 is assigned to conditions that are considered comparable to death, whereas a score of 1 is assigned to those with ‘ideal health.’

While the DALY is considered an appropriate measurement tool to adjust for years of ‘healthy life lost’ due to disability (years of life are ‘disability-adjusted’), the Quality-Adjusted Life Year (QALY) is considered a tool to measure the ‘quality’ of those years (years of life are ‘quality-adjusted’) (Sassi, 2006). The assignments of weights on the same scale as DALYs 0-1 are inverted for QALYs. A score of 0 is assigned to those who are considered to have ideal health, whereas 1 is assigned to conditions close to death. The QALY essentially claims to measure the number of healthy years lived, while the DALY claims to measure years of healthy life lost due to disability.

I am not interested in the specific mathematical steps that are taken to ‘weigh’ DALYs or QALYs, nor am I interested in the ‘reliability’ or ‘validity’ of these tools. I am interested in what these tools allow/disallow for living with a disability. As discussed in Chapter 4, dominant discourses of disability link the idea of living with a disability to that of living with disease or illness. The DALY as a measurement tool to measure ‘years of healthy life lost’ as a result of disability allows for disability to be constructed this way: one year of living with a disability is considered equivalent to one year of ‘healthy’ life lost, again confirming that living with disability and living healthy are incompatible. In this way, it is conceivable that the ‘ideal health situation’ is naturally one that is ‘free’ from disability.

The measurement tools that I have discussed (DALY and QALY) also provide an appropriate context in which to assign meaning of disability alongside other concepts, such as ‘quality of life’ and ‘death.’ In the first part of this chapter, I have outlined how texts bring the concept of disability and death together. It is not surprising that the ideas of disability and death can be linked in the texts when the broader social and political environment is using tools that assign weights to various ‘disability conditions’ that bring them close to death. It is also unsurprising to note the relationship between quality of life and disability in the text. The QALY claims to measure ‘quality years’ that are lived (meaning those that are lived without a disability). A healthcare context that values and promotes ‘quality years’ as those lived without disability, and
a political context that assigns limited healthcare resources to minimizing DALYs and maximizing QALYs, is where the profession of occupational therapy finds itself situated. This broader socio-political context allows for dominant meanings of disability to be associated with a life of limits and as a life that is unimaginable.

5 Summary of Chapter

In the first part of this chapter, I employed a deconstructive approach to examine the text and uncover the ways that disability can come to have meaning. I have read the text for signals or markers that indicate relationships between concepts, and I have proposed various possible interpretations through inference. While inference allows for alternative understandings of the meaning of disability, I do not suggest any intentionality in the possible interpretations that I have illuminated. The dominant discourses surrounding how disability has come to have meaning in the profession of occupational therapy appear to be centered around concepts of health, happiness, flow, and quality of life. While the dominant discourse of imagining life with disability as a life with limits is made possible through the texts, I have also presented an alternative to this that allows life with a disability to be seen as life with possibilities. The ‘limits’ or ‘limitations’ that have been discussed regarding the meaning of life with a disability necessarily create an awareness of freedoms that may otherwise be unnoticeable for those with lives without disability.

In the second part of this chapter, I have highlighted some components of the socio-political context that provide the environment for these interpretations to become possible. I have addressed the impact that concepts, models, and measurement tools developed by the World Health Organization have on the writings in occupational therapy. These broader social and political contexts play an important role in ‘allowing’ for various interpretations and understandings of how the meaning of disability has been re-constructed in occupational therapy. More specifically, I have highlighted the ever-important metrics that have been adopted nationally and internationally to measure the burden of disease through mortality and morbidity.
Chapter 5
Professional Practices of Occupational Therapy

1 Introduction

In Chapter 3, I examined the text for how disability has come to be understood and discussed. I paid specific attention to the vocabulary of disability, and to sentence structures that allow for particular understandings of the word disability. I discussed dominant constructions of disability, including the idea that disability is a problem that is embodied by individuals. In Chapter 4, having already examined what disability is, I focused on examining the text for how disability has been ascribed meaning. I explored the discursive practices surrounding the existential meaning of disability, as well as intersections between the concepts of ‘flow,’ ‘quality of life,’ ‘health,’ and ‘disability.’ In this Chapter I focus on the professional practices of occupational therapy. More specifically, I discuss how the text and dominant discursive practices related to disability have an impact on the profession of occupational therapy. In what position does the profession of occupational therapy find itself? What tensions or challenges exist for the professional practice of occupational therapy? How does the discursive practice of constructing disability in particular ways serve the profession or hold it back?

Assuming that disability is socially constructed, rather than existing as a universal concept, is consistent with a social constructionist perspective. I have used social constructionism as the theoretical framework to examine the ways in which disability is described and ascribed meaning in occupational therapy. Iwama (2006) describes culture as spheres of shared experience. Taking this approach to culture, I conceive the profession of occupational therapy in Canada to be a ‘cultural group’ itself. While occupational therapists will come to the profession with their own values, beliefs, and cultural norms, occupational therapists in Canada are known to share common values and beliefs, as evidenced by the Canadian Association of Occupational Therapists common values and beliefs statement (2015b). Canadian occupational therapists are also known to share common language, and common understandings of appropriate behaviour, as determined and monitored by provincial regulatory bodies. As such, I explore disability as a core concept in occupational therapy that has been socially constructed within this cultural group. I have assumed that disability as a concept is not static or fixed, but rather that ‘truths’
about disability are socially constructed. This allows disability to be constructed and re-constructed in different ways, within and between people.

Consistent with a social constructionist approach, I selected critical discourse analysis as a method to examine Canadian occupational therapy texts. Texts and social action are linked, making text an ideal space to critically examine how disability has come to have meaning in occupational therapy practice. Examining the core constructs in a culture also teaches us about the culture itself (in this case, occupational therapy as a culture). I have chosen an approach to critical discourse analysis that is consistent with the proposed method by Fairclough (2003).

In Chapter 3, I examined what disability is in the text. More specifically I asked: “What is disability?” Through critical analysis of both the text and the images, the dominant construction of disability is that of disability as a ‘thing’ that is located in the person. This is made possible primarily through language, such as person-first language (a person ‘with’ a disability). Moreover, the disability or ‘thing’ is constructed as problematic and deemed to be something that requires ‘fixing,’ ‘minimizing,’ or ‘preventing.’ I propose that disability is seen to be ‘not health,’ in that it appears in the text in close proximity or in relation to concepts such as ‘illness’ or ‘disease.’ As they appear in sentences, those are concepts often separated only by a conjunction (‘and’ or ‘or’). If disability is constructed as ‘not health,’ it seems reasonable that disabled people would require assistance from health professions, specifically occupational therapists.

In Chapter 4, I examined the ways that disability is ascribed meaning in occupational therapy. Inferences were drawn based on implicit underlying assumptions in the text. I proposed intersections between other core concepts in occupational therapy, such as ‘flow,’ ‘quality of life,’ ‘health,’ and ‘happiness.’ The concept of causality was also explored. The distinctions between disability as a condition itself, versus disability as the result of another condition, were illuminated. Finally, I explored the meaning of living with a disability, comparing the view of life with a disability as either a life with limits (this was the dominant discourse in the texts) or a life with possibilities. Imagining disability as a life with limits on the typical freedoms of living portrays an image of a life that is unimaginable.

I will now discuss two additional ideas related to the professional practice of occupational therapy that are prominent in the texts: the ‘positioning’ of the profession and inherent
challenges’ or tensions within the profession. I conclude by examining how the dominant constructions of disability (its existence and meaning) work to serve the profession of occupational therapy, as well as hold the profession back.

2 ‘Positioning’ of the Profession

It is claimed that the concept of ‘positioning’ was first introduced in the business industry by Jack Trout (1969). While the term has evolved over time in various industries, the concept of positioning refers to identifying a market problem and occupying a market niche for the brand, product, or service offered. Positioning is strategic in nature. It requires brands or companies to demonstrate their uniqueness by differentiating themselves from competitors and proving their value.

An examination of occupational therapy texts reveals the concept of positioning, albeit not explicitly described as such. It is not surprising that the Muriel Driver Lectures often ‘call for action’ because one of the intents of the Muriel Driver Lectureship is to stimulate an interest in improving the profession (Finlayson, 2008). A mechanism that is used in the text to appeal for action appears to relate to the concept of positioning. By drawing on the position of the profession, the text affirms for the reader a certain readiness for action. The call for action is achieved through the use of language, such as “occupational therapists are well-positioned to influence” (Desrosiers, 2005, p. 7) and “may I suggest ‘stand to’; take up a position of readiness; take up an attitude of attention; be ready to move” (Basset, 1975, p. 6).

Other texts offer to reaffirm the importance of occupational therapy and call for action to address the lack of awareness and profile of the profession (Polatajko, 1992). In this context, the concept of positioning appears to relate to the use of the term in marketing. Polatajko claims: “our lack of profile is related to our inability to effectively communicate the essential importance of occupational therapy” (1992, p. 3). As it relates to marketing, appropriate positioning would strategically align (or position) the profession to be competitive in the healthcare environment so as to ensure a high profile. The profession would demonstrate its uniqueness to the healthcare team and broader society and prove its essential importance in the healthcare market. In Stan’s (1987) Muriel Driver Lecture, she suggests a more strategic positioning of the profession through her proposed approaches: “The paper reviews the profession’s past response to such forces and develops approaches that occupational therapists individually and collectively can pursue to be
more strategically positioned within the changing health care scene” (Stan, 1987, p. 1). The concept of positioning the profession may speak to the ongoing desire for occupational therapy to remain a viable profession in a competitive healthcare environment.

3 Challenge to the Profession

A second concept that is evident in the text is that of a ‘challenge.’ The word ‘challenge’ has a presence in many of the texts. It signals to the reader a struggle, a competition, a sport, a game, etc. Challenges need to be confronted, overcome, or dealt with in some fashion. Addressing challenges often requires action or movement. Could the ‘challenges’ in occupational therapy signal a sense of ‘competition’ in the health professions? The universal nature of Canadian healthcare services is such that there are limited resources for services to be offered. In the current healthcare environment, health professions are required to demonstrate, through empirical evidence, their effectiveness on health outcomes in order to secure ongoing funding for services. It is standard practice in the current healthcare environment for administrators to conduct model-of-care reviews in order to ensure that the most appropriate health provider is providing the most appropriate care in the most appropriate environment. Such model-of-care reviews address what services are being offered and who is providing the service. Given the nature of occupational therapy practice, and the increased overlapping of scope of practice in the health professions, it is possible that occupational therapy is challenged to compete with other professionals in the provision of health services.

Other challenges for the profession that are evident in the texts appear in the form of tensions, and many of the texts explicitly address several challenges faced by the profession. One such challenge or tension is that of dissonance. It has been well established and discussed in occupational therapy, rehabilitation, and disability studies literature that there is a discord between the core philosophical values of the profession and those of the medical system. Friedland states:

If the very nature of the problem is the disability itself, and efforts are directed at eliminating it, then occupational therapists are at a disadvantage, because for us, the very nature of the problem itself is not the disability but the occupational performance of the person with the disability. (Friedland, 1997, p. 373)
Similarly, Roush and Sharby (2011) discuss the implications of a changing notion of disability on the profession of physiotherapy: “It is paradoxical for PT to simultaneously work to ameliorate disability while celebrating it as diversity” (p. 1715).

One tension that speaks to dissonance between occupational therapy and other rehabilitation and medical professions is that of ‘holism.’ The notion of holism is present in the texts when referring to occupational therapy practice. Holism in occupational therapy texts is often described as considering the ‘whole person’ in the provision of services. While this is a dominant discourse that is present in occupational therapy texts, it conflicts with the environment in which occupational therapists provide services. As discussed in Chapter 4 (specialization of health services) and Chapter 5 (cause/effect), the healthcare environment is one that is reductionist in nature. When occupational therapy practice is conducted in a competitive, reductionist environment, the underlying principles of occupational therapy that reject a reductionist view of the person in favour of a holistic approach are in direct conflict with that environment. While holism remains a dominant discourse in occupational therapy texts, it appears to be a challenge for professional practices that continue to require occupational therapists to break the body into parts and address component parts as they relate to health outcomes.

4 How Do Constructions of Disability Serve the Profession?

In Chapters 3 and 4, I have discussed the dominant discourses surrounding the notion of disability in occupational therapy texts. I have addressed how disability has been socially constructed in Canadian occupational therapy culture, and I have examined the meanings that have been attached to this concept. Constructing disability in particular ways serves the profession of occupational therapy. I will now address how social constructions of disability in occupational therapy texts serve the profession.

The notion that disability is problematic in nature—that it is an embodied ‘thing’ that disabled people possess that either leads to or is by nature of its existence categorized with illness and disease (‘not-health’)—has very important implications. Constructing and reconstructing disability in this way allows for interventions by health professions (i.e., to address ‘not health’). More specifically, it allows for occupational therapy interventions to focus on the person with the disability as the cause of problematic health outcomes. This results in the notion that the person
with the disability is in fact the ‘work-object’ of occupational therapists (Abberley, 1995). Disabled people become the focus of work for occupational therapists who attempt to minimize, eliminate, or prevent disability.

The nature of the relationship between health professional and client results in a power differential based on the specialized knowledge and expertise that the professional holds. Constructing disability as a problem to be solved by occupational therapy preserves the perception that occupational therapists have specialized knowledge and, therefore, power over the client, which serves to maintain the hierarchical nature of the client/therapist relationship. When disability is constructed as a universal concept with standardized meanings worldwide, it provides opportunity to measure disability, count it, and statistically compare its rates across services areas, populations, and even countries. Given that empirical, data-driven evidence is privileged in healthcare, participating in reconstructing disability as something that occupational therapy can measure serves the profession.

It may serve the profession to construct disability as something to be measured; however, this approach does not come without tensions—which I am acutely aware of, as an administrator in a hospital. While I have come to understand and appreciate disability as a socially constructed phenomenon, it is the individual improvements on standardized assessment tools (efficacy of therapy), combined with shortened lengths of stay (efficiency of therapy), that are used in funding formulae to secure sufficient funding to maintain rehabilitation services. Like many occupational therapists in the current healthcare environment, I am often faced with the challenge of balancing these tensions—believing that disability is socially constructed, while understanding that measurement of disability (as universally constructed) is a necessary tool to secure resources to support therapy services.

If disability is framed as a life with limits on the typical freedoms of living, it allows for healthcare professionals to collectively work to eliminate the disability. Given that this is the dominant way of relating to disability in the health professions, it serves the profession of occupational therapy to relate to disability in a similar way. The shift in Canadian healthcare service delivery is increasingly focused on interprofessional collaboration. Interprofessional teams work together with clients on integrated goals that cross professional boundaries. Interprofessional collaboration has received widespread global support and is endorsed by the
World Health Organization as the most efficient and effective way to deliver health services (WHO, 2010). As such, relating to disability in ways that are consistent with other professions in the healthcare environment ensures that occupational therapists can relate to and communicate with interprofessional teams. This is necessary in order to ‘fit in’ with the team.

5 How Do Constructions of Disability Impede the Advancement of the Profession?

Despite the profession being served by constructing disability in particular ways, there are also ways that retaining particular views of disability impede the advancement of the profession. Constructing disability in certain ways essentially means eliminating other ways of seeing the same phenomenon. I now discuss how dominant discourses of disability that have been socially constructed in the profession of occupational therapy limit the profession.

The dominant discourses of disability, as an existential corporeal thing that is embodied by disabled people, is evident in occupational therapy. When disability is constructed in this universal way, it can be assumed that the ‘truth’ surrounding what disability is has already been discovered (Titchkosky, 2007). It is, after all, something that has already been clearly defined as universal rather than socially constructed. This way of viewing disability keeps occupational therapists from continuing to critically examine what disability is—and what disability means. Critical approaches to examining texts as cultural artifacts to uncover new meanings of disability is not necessary if disability is believed to be an already defined universal concept.

This way of viewing disability limits the profession of occupational therapy in establishing alternative ways of knowing about disability. In turn, when disability and the measurement tools that have emerged based on this understanding of disability are uncritically adopted, it limits the types of new knowledge that occupational therapy is able to produce. The profession will only be able to reproduce particular understandings of disability if standardized measurement tools that depend on a specific understanding of disability are utilized. Eliminating alternative possibilities could be seen to limit the potential for occupational therapy to apply creative and new ways of considering and, thus, measuring disability.
6 Implications for Occupational Therapy

The dominant discourses of disability in the Muriel Driver Lectureships include understanding disability as an individual embodied experience that is problematic or dysfunctional in nature. Critical examination of the dominant discourses has implications for the future of occupational therapy education, practice, policy, and research in Canada. The results of my research call for including new and alternative ways of thinking about, and understanding, disability into occupational therapy curriculum—such that disability becomes a concept in the curriculum that is understood as a social construct. Of course, understanding disability as a social construct would require taking a post-modern and social constructionist perspective, and would only be possible if these types of perspectives were broadly accepted and adopted in the occupational therapy curriculum.

Calling into question a singular notion of disability has implications on the practice of occupational therapy. The way that clinicians make sense of the word ‘disability’ frames the types of assessment tools they choose and the intervention plans they create with and for clients. Occupational therapists who understand disability to be a socially constructed phenomenon will necessarily seek to understand what disability means to their clients, in order to promote or provide the most relevant and valuable therapy services. There is a need for occupational therapists to ‘slow down’ when they are confronted with disability and, furthermore, to reflect on their own assumptions surrounding the concept of disability.

Destabilizing the concept of disability within the profession of occupational therapy—to mean more than dysfunction or an individual problem—means allowing new ways for occupational therapists to become involved in setting disability policy through advocacy. Issues such as eligibility and access to health and social services are largely discussed in relation to how concepts such as disability are defined (e.g., only those with specific diagnoses are eligible for specific services, and the mandates of various services are set through policies that define and address disability in very specific ways). Occupational therapists have the opportunity to address issues surrounding disability by engaging the meanings of disability at the policy level.

Taking philosophical and epistemological approaches—such as social constructionism—in the development of new knowledge through theory and research will allow for growth in the
profession of occupational therapy. Critiques of contemporary occupational therapy theory and models have been met with the development of innovative models, such as the Kawa model (Iwama, 2006) to guide clinical practice. The results of this study call for considering disability (along with other core concepts in occupational therapy) as a social construct in the development of new theory and models to expand the theoretical base for occupational therapy and ensure its relevancy moving forward.

7 Future Directions

Building on the findings of this study, future research examining how the dominant constructions of disability in occupational therapy are enacted in social relations (including relations between clients and therapists) is warranted. Ethnographic studies conducted in clinical settings would provide an opportunity to examine how understandings of the meaning of disability are enacted in clinical encounters. Furthermore, future studies using critical discourse analysis as proposed by Fairclough would shed additional light on the ways that disability is constructed in the profession. For example, analyzing medical records (i.e., how therapists write about disability) in relation to therapeutic interventions would provide insight into how constructions of disability are conceived and acted upon in clinical encounters.

Finally, other theoretical and methodological approaches to examining the social construction of disability in occupational therapy would further the findings of this study. More fully exploring the complex social systems that reinforce power as it relates to understanding disability using Foucauldian discourse analysis would have much to offer the profession of occupational therapy. The opportunities for occupational therapy to further explore and critically examine the core concepts in the profession are endless.

8 Summary of Chapter

In this Chapter, I have drawn on the analysis presented in previous chapters to discuss how particular constructions of disability ‘live’ in the professional practices of occupational therapy. I have discussed the concept of ‘positioning’ as it relates to occupational therapy’s role (or position) within the ever-changing healthcare environment. I borrow the notion of positioning from the marketing industry, but it appears to make an appearance implicitly in occupational
therapy texts. Concerns about ‘challenges’ or tensions in the profession also appear in the texts in various forms.

Finally, the implications of how dominant constructions of disability have come to serve the profession of occupational therapy, as well as hold it back, have been discussed. It is important to note that the conventions that underlie discourse are shaped by dominant ideologies, which are typically so universally accepted that they are often assumed or implicit. I am proposing that the profession of occupational therapy needs to ‘slow down.’ Slowing down and taking critical ‘pauses’ are necessary in order to consider the ways that core concepts in the profession are being constructed and re-constructed. Occupational therapists should slow down in their readings of text, pause and consider the words that are written on the page, and critically consider what the discourse allows and limits. While it may seem unreasonable, it has been argued that there is a fine line between having a problem (called disability) and being the problem, between not valuing a condition (like disability) and not valuing a person (Titchkosky, 2001; Hammell, 2006). There are no better reasons to slow down in text and social action than to ensure that disabled people are not conceived of as being problematic or less valuable in society. This is particularly true for writings in the profession of occupational therapy, whereby discourses of disability are prominent and impact social action.
Afterword

Reflections and Directions

As an occupational therapist critically examining occupational therapy text, I can be seen as an ‘insider’ in this research. This has required a deliberate and reflective process to ensure that I remained open to the various ways that disability has been constructed in text. Exploring constructions of disability in occupational therapy has led me to a deeper understanding and appreciation of the importance of language—and the many ways that language is social action. I have examined the dominant discourses in occupational therapy, which demonstrate how disability is constructed in occupational therapy literature. More specifically, I have addressed the research objectives: how is disability presented in occupational therapy literature, what does this tell us about the ideological, political, and theoretical underpinnings of disability, and finally, what are the dominant discourses of disability in occupational therapy literature?

I hope that this work can make a contribution to the profession, in that I have highlighted the ways that Canadian occupational therapists have socially constructed one of the core concepts in the profession of occupational therapy, as well as the implications this has on the profession. Without explicitly examining the meanings of disability in occupational therapy, we risk naturalizing the notion of disability in the text, such that its invisible determinants have the potential to do harm—despite good intentions.

While my research has focused exclusively on occupational therapy, I believe there are parallels that can be drawn with other health disciplines, primarily in the rehabilitation sciences. Given that I have completed this research for degree requirements, time constraints have limited my ability to include additional methods to further explore the construction of disability in occupational therapy. In order to continue the exploration of how disability has come to have meaning in occupational therapy practice, future research would be warranted focusing not only on the texts themselves, but also on the interpretations of the texts in practice environments (Fairclough, 2003). This would support arguments that textual analysis is strengthened when partnered within ethnography. Future ethnographic research examining how disability through text is enacted socially is warranted.
In order to accomplish my research, I have critically examined texts written by esteemed leaders in the profession of occupational therapy in Canada. Without the exceptional leadership and courage of these influential figures in Canadian occupational therapy, my research would not be possible. It seems fitting to reflect again on the fact that my research has not attempted to uncover the intentions of the authors in their writing of the Muriel Driver Lectureships, but rather to determine the possibilities and impossibilities that have materialized from their lectures. Of utmost importance is the awareness that language, dialectically related to social action, is socially, historically, and culturally situated—and that the Muriel Driver Lectureships reflect a larger social context within which the lectures were delivered.

Lastly, I have attempted through the research to question the stability of the concept of disability as a ‘truth’ that is static within the profession. By destabilizing the concept of disability, I hope to have permitted and encouraged alternative meanings of disability to emerge.
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http://apps.who.int/iris/bitstream/10665/70185/1/WHO_HRH_HPN_10.3_eng.pdf


## Appendix 1. Muriel Driver Memorial Lectureships (1975-2009)

<table>
<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>Joy Bassett</td>
<td>No title</td>
</tr>
<tr>
<td>1976</td>
<td>Margaret R. Hood</td>
<td>No title</td>
</tr>
<tr>
<td>1977</td>
<td>Barbara J. O’Shea</td>
<td>Pawn or protagonist: Interactional perspective of professional identity</td>
</tr>
<tr>
<td>1979</td>
<td>Gail B. Gilewich</td>
<td>Managers in occupational therapy</td>
</tr>
<tr>
<td>1980</td>
<td>Elizabeth B. Bell</td>
<td>Directions for the decade</td>
</tr>
<tr>
<td>1981</td>
<td>Isobel M. Robinson</td>
<td>The mists of time</td>
</tr>
<tr>
<td>1982</td>
<td>Mary Judd</td>
<td>No title</td>
</tr>
<tr>
<td>1983</td>
<td>Andree Forget</td>
<td>Application d’un paradigme systémique à l’évaluation ergothérapique des personnes âgées</td>
</tr>
<tr>
<td>1984</td>
<td>Barbara Saunders</td>
<td>Quality assurance- Reflections on the wave</td>
</tr>
<tr>
<td>1985</td>
<td>E. Sharon Britnell</td>
<td>Career planning in occupational therapy: I want up, not out</td>
</tr>
<tr>
<td>1986</td>
<td>Thelma Gill</td>
<td>You can’t take it with you!</td>
</tr>
<tr>
<td>1987</td>
<td>L. Joanne Stan</td>
<td>Making our mark in the marketplace</td>
</tr>
<tr>
<td>1988</td>
<td>Susan Baptiste</td>
<td>Chronic pain, activity and culture</td>
</tr>
<tr>
<td>1989</td>
<td>Margaret Tompason</td>
<td>Ripples to tidal waves</td>
</tr>
<tr>
<td>1990</td>
<td>Anne Carswell-Opzoomer</td>
<td>Occupational therapy- Our time has come</td>
</tr>
<tr>
<td>Year</td>
<td>Author</td>
<td>Title</td>
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<tr>
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</tr>
<tr>
<td>1991</td>
<td>Mary Law</td>
<td>The environment: A focus for occupational therapy</td>
</tr>
<tr>
<td>1992</td>
<td>Helene J. Polatajko</td>
<td>Naming and framing occupational therapy: A lecture dedicated to the life of Nancy B.</td>
</tr>
<tr>
<td>1993</td>
<td>Elizabeth Townsend</td>
<td>Occupational therapy’s social vision</td>
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<td>Huguette Picard-Greffe</td>
<td>Back to the future</td>
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<td>Marie Gage</td>
<td>From independence to interdependence: Creating synergistic health care teams</td>
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<td>Muriel Westmorland</td>
<td>Risk taking: An antidote to diffidence</td>
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<td>Mary Ann McColl</td>
<td>Spirit, occupation and disability</td>
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<td>2001</td>
<td>Virginia G. Fearing</td>
<td>Change: Creating our own reality</td>
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<td>2003</td>
<td>Judith Friedland</td>
<td>Why crafts? Influences on the development of occupational therapy in Canada from 1890-1930</td>
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<td>2004</td>
<td>Catherine L. Backman</td>
<td>Occupational balance: Exploring the relationships among daily occupations and their influence on well-being</td>
</tr>
<tr>
<td>2005</td>
<td>Johanne Desrosiers</td>
<td>Participation and occupation</td>
</tr>
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<td>2006</td>
<td>Jan Miller Polgar</td>
<td>Assistive technology as an enabler to occupation: What’s old is new again</td>
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<tr>
<td>2007</td>
<td>Mary Egan</td>
<td>Speaking of suffering and occupational therapy</td>
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<tr>
<td>2008</td>
<td>Terry Krupa</td>
<td>Part of the solution…or part of the problem?</td>
</tr>
<tr>
<td>Year</td>
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</tr>
<tr>
<td>2009</td>
<td>Nicol Korner-Bitensky</td>
<td>Occupational therapy: A thread that weaves a lifetime</td>
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</table>
Appendix 2. Data Analysis Sheet

TITLE:

DATE OF PUBLICATION:

DATE(S) OF ANALYSIS:

Fairclough’s Three Dimensional Analysis (Fairclough, 1992)

1) **Description** (examining the organization of the text, its structure, and vocabulary)

**Function:** What is the text trying to do?

**Vocabulary:** What types of individual words are used?

What type of language is used to describe disability? (i.e., person-first language)

**Cohesion:** How are sentences and ideas about disability linked together?
Text Structure: What large-scale organizational properties are used in the text?

Coherence of Texts: Are there direct connections based on ideological assumptions?

Intertextuality: Are other texts being referenced? Referred to? Is this explicit or implicit?

2) Interpretation (of the interaction processes and their relationship to text: moment by moment analysis of how participants produce/interpret the texts by specifying discursive practices that are being used and in which combinations)

Who is the producer?

What are the social constraints as to how it is being produced?
What aspects of members’ resources are used to understand the text? What assumptions are being made?

3) **Explanation** (of how the interaction process relates to the social action: explain the properties of the interaction by referring to its social context and assess its contribution to social action- effectiveness in constituting or helping to reconstitute different dimensions of the social in the interpretation phase)

**Ideology:** How does the text constitute disability?

Is disability ‘naturalized’ in the text?

Does the idea of disability sustain or change significations of the world?
What assumptions are being made? What do these assumptions allow? Disallow?

**Hegemony:** Are there implicit practices that have become naturalized that expose the constant struggle?

**Political:** How does the text establish power relations?

How does the text sustain or change power relations?

**Problematization**

What is the problem?

Where is the problem located? (individual/society?)
What characteristics of ‘disabled people’ are described? Promoted? Seen as ideal?

**Other questions to guide analysis**

Are there inconsistencies and contradictions evident in the text?

What statements are ‘hedged’? (it appears, it seems)/less confident in ‘truthfulness’?
Appendix 3. Preliminary Data Analysis Patterns

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Author</td>
<td>Joy Basset</td>
</tr>
<tr>
<td>Title</td>
<td>No Title</td>
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**Representation of Social Actors: Named/Classified**

"We have also over the years developed skills in adapting equipment to fit the special requirements of the handicapped" (p.2); "There is a tremendous [sic] future for occupational therapists in the field of Mental Retardation; that research must be undertaken into the most effective methods of treating and training the mentally retarded, and that therapists must become a more informed body of knowledge and develop more areas of expertise..." (p.5); "a therapist who, for the past two years, was working in a government institution for the mentally retarded..." (p.5)

**Disability as a Problem: Semantic Relations and Value Assumptions**

"...seriousness of the problem can be seen from the following facts: ...between 5% and 10% of school children suffer from mental or learning disorders" (p2); "she runs a parents class to help them handle their very small children, many of which have multiple problems" (p.4); "There is a tremendous [sic] future for occupational therapists in the field of Mental Retardation; that research must be undertaken into the most effective methods of treating and training the mentally retarded, and that therapists must become a more informed body of knowledge and develop more areas of expertise..." (p.5)

**Representations of Social Actors: Activated/Passivated**

There is a tremendous [sic] future for occupational therapists in the field of Mental Retardation; that research must be undertaken into the most effective methods of treating and training the mentally retarded, and that therapists must become a more informed body of knowledge and develop more areas of expertise... (p.5)

**Relations of Collocation: Disability/Health/Illness/Dysfunction**

**Occupational Therapy Practice**

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2 Emphasis has been added to lectureships published in *Muriel Driver Memorial Lecture Anthology* (CAOT, 2001)
<table>
<thead>
<tr>
<th>Year</th>
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<tr>
<td>Author</td>
<td>Barbara O'Shea</td>
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<tr>
<td>Title</td>
<td>Pawn or protagonist: Interactional perspective of professional identity</td>
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<tr>
<td>Representation of Social Actors: Named/Classified</td>
<td>Quoted from 1933 CJOT, &quot;For example, we do not use the term 'patient' at all, but rather 'guest'… The rather oppressive title of 'occupational therapy class' with its unfortunate association with feeble-mindedness, or serious mental disease, drab surroundings and large rooms filled with looms and basketry, has been abolished in favour of the more attractive name of 'Hobby Shops'. Likewise we have no 'occupational therapists', or even 'aides', but rather instructors in arts and crafts and tutors in special work&quot; (p.2); &quot;The normal relationship negotiated between professional and client casts the client in the role of the person being helped&quot; (p. 3)</td>
</tr>
<tr>
<td>Disability as a Problem: Semantic Relations and Value Assumptions</td>
<td>“The normal relationship negotiated between professional and client casts the client in the role of the person being helped? (p. 3)</td>
</tr>
<tr>
<td>Representations of Social Actors: Activated/Passivated</td>
<td>“The normal relationship negotiated between professional and client casts the client in the role of the person being helped” (p. 3); &quot;The manner of 'doing to' a client rather than 'doing with' a client was another interesting faculty message conveyed to students in numerous ways throughout the class. The course objectives presented at the beginning of the semester repeatedly pointed to students functioning independently of clients, not in conjunction with clients&quot; (p.6)</td>
</tr>
<tr>
<td>Relations of Collocation: Disability/Health/Illness/Dysfunction</td>
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<tr>
<td>Meaning of Disability</td>
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<tr>
<td>Occupational Therapy Practice</td>
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<tr>
<td>Year</td>
<td>1987</td>
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<tr>
<td>Author</td>
<td>L. Joanne Stan</td>
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<tr>
<td>Title</td>
<td>Making it our mark in the marketplace</td>
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**Representation of Social Actors: Named/Classified**

"Our commitment to the service of disabled members of society has been the foundation of practice and remains a motivation for many practitioners" (p.2); "We talk about the importance of working with rather than doing to a client in need of our assistance" (p.3); "Furthermore, equality legislation, government policies on de-institutionalization and a focus on the abilities of the disabled, reflect a health consciousness clearly compatible with the wellness orientation of occupational therapy" (p.5);

**Disability as a Problem: Semantic Relations and Value Assumptions**

“We talk about the importance of working with" rather than "doing to" a client in need of our assistance" (p.3)

**Representations of Social Actors: Activated/Passivated**

“We must use our knowledge of disease and disabling conditions within a framework of social systems rather than in the confines of the treatment facility” (p.5); "We talk about the importance of working with" rather than "doing to" a client in need of our assistance" (p.3)

**Relations of Collocation: Disability/Health/Illness/Dysfunction**

“We must use our knowledge of disease and disabling conditions within a framework of social systems rather than in the confines of the treatment facility” (p.5); “Furthermore, equality legislation, government policies on de-institutionalization and a focus on the abilities of the disabled, reflect a health consciousness clearly compatible with the wellness orientation of occupational therapy” (p.5)

**Meaning of Disability**

**Occupational Therapy Practice**
<table>
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<th>Year</th>
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<tr>
<td><strong>Author</strong></td>
<td>Susan Baptiste</td>
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<tr>
<td><strong>Title</strong></td>
<td>Chronic pain, activity, and culture</td>
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<td><strong>Representation of Social Actors: Named/Classified</strong></td>
<td>&quot;These patients (people suffering with chronic pain) become dysfunctional in many components of their lifestyle and feel that they have abrogated control over their lives to a continuous stream of health care professionals, from whom they seek care and cure&quot; (p.3); &quot;The crux of the chronic pain patient's dilemma: the agony of accepting the loss of old skills, the present sense of failure, and the fear of future uselessness&quot; (p.4)</td>
</tr>
<tr>
<td><strong>Disability as a Problem: Semantic Relations and Value Assumptions</strong></td>
<td>“These patients (people suffering with chronic pain) become dysfunctional in many components of their lifestyle and feel that they have abrogated control over their lives to a continuous stream of health care professionals, from whom they seek care and cure” (p.3)</td>
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<td><strong>Representations of Social Actors: Activated/Passivated</strong></td>
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</tr>
<tr>
<td><strong>Relations of Collocation: Disability/Health/Illness/Dysfunction</strong></td>
<td>“These patients (people suffering with chronic pain) become dysfunctional in many components of their lifestyle and feel that they have abrogated control over their lives to a continuous stream of health care professionals, from whom they seek care and cure” (p.3); &quot;The writer chooses to define &quot;culture&quot; in relation to differing ethnicities, rather than referent to socio-economic differences, sexual preferences or minority group status (i.e. gender, disability, disease status)” (p.3)</td>
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<tr>
<td><strong>Meaning of Disability</strong></td>
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<tr>
<td><strong>Occupational Therapy Practice</strong></td>
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<td>Year</td>
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<tr>
<td>Author</td>
<td>Anne Carswell-Opzoomer</td>
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<tr>
<td>Title</td>
<td>Occupational therapy - Our time has come</td>
</tr>
<tr>
<td>Representation of Social Actors: Named/Classified</td>
<td>&quot;The present care system rarely if ever improves the health of disabled persons, persons with emotional or developmental disorders, socially disadvantaged persons, the elderly, or persons whose environment is harmful&quot; (p.2)</td>
</tr>
<tr>
<td>Disability as a Problem: Semantic Relations and Value Assumptions</td>
<td>&quot;The loss of a sense of control, the reduced social interaction and communication, place the person under increased stress without the power to react in a constructive way. This stress was shown to have specific physiological and psychological effects leading to illness and dysfunction&quot; (p.4); &quot;Services which promote good health, a healthy environment, adequate community and family support, which prevent illness and disability, which support people living in their home in their own way will be provided by collaborating professional and voluntary organizations&quot; (p. 5)</td>
</tr>
<tr>
<td>Representations of Social Actors: Activated/Passivated</td>
<td>&quot;Services which promote good health, a healthy environment, adequate community and family support, which prevent illness and disability, which support people living in their home in their own way will be provided by collaborating professional and voluntary organizations&quot; (p. 5); “Occupational therapy empowers people to achieve their potential and live a meaningful life. It provides the guidance and instruments for clients to attain their goals and objectives” (p.6)</td>
</tr>
<tr>
<td>Relations of Collocation: Disability/Health/Illness/Dysfunction</td>
<td>“An initial step would be to match our paradigm of practice with a health paradigm based upon determinants of health, rather than upon the determinants of illness and disability” (p.3); &quot;The loss of a sense of control, the reduced social interaction and communication, place the person under increased stress without the power to react in a constructive way. This stress was shown to have specific physiological and psychological effects leading to illness and dysfunction&quot; (p.4); &quot;Services which promote good health, a healthy environment, adequate community and family support, which prevent illness and disability, which support people living in their home in their own way will be provided by collaborating professional and voluntary organizations&quot; (p. 5)</td>
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</table>
| Meaning of Disability | “Occupational therapy empowers people to achieve their potential and live a meaningful life. It provides the guidance and instruments for clients to attain their goals and objectives. It
<p>| Occupational Therapy Practice | sustains an environment in which the client can experience the same joys and miseries of life and can experience similar feelings of achievement, value and self-worth as do all of us” (p.6) |</p>
<table>
<thead>
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<tr>
<td>Author</td>
<td>Mary Law</td>
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<td>Title</td>
<td>The environment: A focus for occupational therapy</td>
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<tr>
<td>Representation of Social Actors: Named/Classified</td>
<td>&quot;Increasingly, people are concerned about the lack of rights of people with disabilities and the problems inherent within our environment which cause significant difficulties for people who have a disability&quot; (p.2); &quot;People with disabilities spend more time in self-care and passive activities within their home environments than the non-disabled&quot; (p.2); &quot;The separation of private and public space, decreased political influence of the home and safety and accessibility difficulties combine to impede the integration of people with disabilities&quot; (p.2); &quot;For example, children with disabilities are judged by their differences from the norm without considering that they may have their own pattern of &quot;normal&quot; development&quot; (p.3); &quot;People with disabilities have little political power and are expected to comply with treatment&quot; (p.3); &quot;There are also potential problems with fixed environmental standards. Fixed standards effectively discount the experiences of people with disabilities who use these environments&quot; (p.6)</td>
</tr>
<tr>
<td>Disability as a Problem: Semantic Relations and Value Assumptions</td>
<td>&quot;Disability often leads to occupational dysfunction. Individuals can change dysfunction through the therapeutic use of purposeful activity&quot; (p.4); &quot;There are substantial differences in the use of time or activity patterns between individuals with a disability and those with no disability&quot; (p.4); &quot;The approach to disability has focused on the individual and the immediate environment. Problems in the built environment, our emphasis on normality, concentration of power and increased bureaucracy are identified as some important factors which have led to disabling environments&quot; (p.3); &quot; Disability is seen as a collective problem, a problem caused by the inadequacies of the environments in which we live (Funk, 1987), not always to be ameliorated by changing the individual&quot; (p.6)</td>
</tr>
<tr>
<td>Representations of Social Actors: Activated/Passivated</td>
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<td>Relations of Collocation: Disability/Health/Illness/Dysfunction</td>
<td>&quot;Disability often leads to occupational dysfunction. Individuals can change dysfunction through the therapeutic use of purposeful activity&quot; (p.4)</td>
</tr>
<tr>
<td><strong>Meaning of Disability</strong></td>
<td>&quot;Experiences in a wide variety of supportive environments are necessary for optimal living. People with disabilities are able to achieve these experiences because the environments in which they live have many constraints&quot; (p.8); &quot;They do however, represent an alternate vision for the future, a future in which people with disabilities are equal participants in the daily activities or our communities” (p.8)</td>
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<tr>
<td><strong>Occupational Therapy Practice</strong></td>
<td>“This is a challenge to see disability in a new way. It represents an addition to the client-centred model of occupational therapy practice model. If environments foster dependency and poor resolution to the problems of disability, then solutions will exist predominantly in intervention aimed at modification of the environment...an improved balance in intervention focus is required (p.6); Future - &quot;The overriding goal of occupational therapy intervention to change disabling environments is to achieve equity through critique and change. Disability is seen as a collective problem, a problem caused by the inadequacies of the environments in which we live (Funk, 1987), not always to be ameliorated by changing the individual&quot; (p.6)</td>
</tr>
<tr>
<td>Year</td>
<td>1992</td>
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</tr>
<tr>
<td>Author</td>
<td>Helene J. Polatajko</td>
</tr>
<tr>
<td>Title</td>
<td>Naming and framing occupational therapy: A lecture dedicated to the life of Nancy B.</td>
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</tbody>
</table>

**Representation of Social Actors: Named/Classified**

"Never in the history of Canada, or the disabled, have we been more challenged by diversity" (p.2); “As occupational therapists we should put all our energies into doing everything we can to ensure that diversity in any form, be it cultural, racial, or ability based, be tolerated. Not just tolerated, but respected. Not just respected, but celebrated" (p.2); Disablement Model (WHO) definitions "Impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function resulting from any cause disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being; and handicap is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment [sic] of a role that is normal" (p.7); "I suggest that occupational therapy must focus on handicap, not disability and that impairment and disability would only be considered with respect to their contribution to handicap" (p.7); "It follows that handicap is the proper focus for occupational therapy. Handicap, not disability is defined in terms of the environmental influence on function" (p.7); "The classic symbol of handicap (lower left corner), is that of a person with an ambulation disability in a box. The box is considered to symbolize the constraints placed on the individual with disabilities. Occupational therapy, works with the individual to minimize disability and environmental constraints (middle drawing) so as to enable living (right drawing)" (p.10)

**Disability as a Problem: Semantic Relations and Value Assumptions**

"Framed in the disablement model, occupational therapy is a discipline concerned with handicap reduction or prevention" (p.8); "The classic symbol of handicap (lower left corner), is that of a person with an ambulation disability in a box. The box is considered to symbolize the constraints placed on the individual with disabilities. Occupational therapy, works with the individual to minimize disability and environmental constraints (middle drawing) so as to enable living (right drawing)" (p.10)

**Representations of Social Actors: Activated/Passivated**

"The classic symbol of handicap (lower left corner), is that of a person with an ambulation disability in a box. The box is considered to symbolize the constraints placed on the individual with disabilities. Occupational therapy, works with the
individual to minimize disability and environmental constraints (middle drawing) so as to enable living (right drawing)” (p.10)

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<tr>
<th>Relations of Collocation: Disability/Health/Illness/Dysfunction</th>
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Meaning of Disability

"When therapists stress independence or maximum potential they are reflecting the valuing of perfection. However, inherent in the valuing of perfection is the *devaluing of those who are less than perfect, including those who have disabilities*. This is clearly dissonant with our belief in the dignity and worth of each individual” (p.6); "The *classic symbol of handicap* (lower left corner), is that of a person with an ambulation disability in a box. The box is considered to symbolize the *constraints placed on the individual with disabilities*. Occupational therapy, works with the individual to minimize disability and environmental constraints (middle drawing) so as *to enable living* (right drawing)” (p.10)

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<td>Year</td>
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<tr>
<td>Author</td>
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<tr>
<td>Title</td>
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**Representation of Social Actors: Named/Classified**
"…we interviewed sixteen people with recently acquired disabilities about spiritual issues that might have arisen for them since the onset of their disability" (p.1); "We spoke with 12 men and 4 women, with an average age of 40, and an average duration of disability of 23 months, all of whom had had a traumatic-onset disability (spinal cord injury or brain injury)" (p.1); "Disability study questions - Has your understanding of yourself changed since you acquired your disability?" (p.2); "Occupational therapy study questions - Have you seen people whose understanding of themselves has changed when they acquired a disability?" (p.2); "Finally, it has been suggested that events like the onset of a disability arouse doubts in our assumptions about the essential goodness of the world" (p.5); (p.6); "it is clear that some people experience spirit in the face of disability as a moral judgment on a life not properly lived" (p.6); "The implication of this view is that disabled individuals lives not only with the difficulties imposed by the disability, but also with some combination of confusion, guilt and shame" (p.6)

**Disability as a Problem: Semantic Relations and Value Assumptions**
"The disability and its implications are so pervasive and overwhelming that they impel individuals to seek meaning in spiritual terms; that is to seek answers in the realm of the mysterious, the unknown or the unexplainable" (p.5); Disability may separate individuals from the capacities that previously permitted them to experience and express spirit" (p.5); "The implication of this view is that disabled individuals lives not only with the difficulties imposed by the disability, but also with some combination of confusion, guilt and shame" (p.6)

**Representations of Social Actors: Activated/Passivated**

**Relations of Collocation: Disability/Health/Illness/Dysfunction**

**Meaning of Disability**
"Often disability brings individuals even closer either to death or to the idea of death" (p.5); "Finally, it has been suggested that events like the onset of a disability arouse doubts in our assumptions about the essential goodness of the world" (p.5); "In order to restore meaning in the chaos of disability,
individuals are often impelled to a re-examination of basic beliefs and a *renewed search for meaning*" (p.5); "Referring to both our interviews with people with disabilities and to the literature, it seems that there are at least four ways in which individuals experience spirit when *disability overtakes their world*" (p.5); "One way that spirit was experienced by our participants in relation to their disability was a reminder of their *physical vulnerability and mortality*" (p.5); "Some participants stated that they *did not have a purpose before their injury, but now did as a result of their disability*" "We know that there are some activities that are more likely to invoke the presence of spirit. Activities that are antecedents to spiritual experience can be categorized as either existential, meditative or creative. We have already talked about *existential antecedents* to spiritual experiences, specifically the disability itself" (p.9); "one therapist told me of a client who had made a ritual of honouring the *new self by burying something that had been a symbol of the pre-disability self*" (p.9)

<p>| Occupational Therapy Practice | “…two central concepts in occupational therapy: disability and occupation” (p.10) |</p>
<table>
<thead>
<tr>
<th>Year</th>
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<tbody>
<tr>
<td>Author</td>
<td>Johanne Desrosiers</td>
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<tr>
<td>Title</td>
<td>Participation and occupation</td>
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**Representation of Social Actors: Named/Classified**

"Studied the explanatory factors of restriction in participation of *adults who had chronic disabled conditions* such as neuromuscular disorder, spinal cord injury, rheumatoid arthritis, stroke or fibromyalgia" (p.6); "In Quebec, traditionally there are no well-organized occupational therapy services for *people with chronic disabling conditions* such as *those who have had a stroke*" (p.6); "What do we know about the participation of *people who have mental health problems*?" (p.7); "How should we assess and influence participation of *people with cognitive deficits*?" (p.7)

**Disability as a Problem: Semantic Relations and Value Assumptions**

“What do we know about the participation of people who have mental health *problems*?” (p.7); "How should we assess and influence participation of people with cognitive *deficits*?” (p.7)

**Representations of Social Actors: Activated/Passivated**

“How should *we assess and influence* participation of *people with cognitive deficits*?” (p.7); “Activity or capability was operationalized by the concept of functional independence that refers to the capacity to do tasks or activities. Traditionally, functional independence was considered by most *rehabilitation professionals and researchers* as the *key outcome to allow people to be successful* in their return to community living after an episode of rehabilitation” (p.5)

**Relations of Collocation: Disability/Health/Illness/Dysfunction**

“…*chronic disabled conditions* such as neuromuscular disorder, spinal cord injury, rheumatoid arthritis, stroke or fibromyalgia” (p.6)

**Meaning of Disability**

“*How should* we assess and influence participation of people with cognitive *deficits*?” (p.7)

**Occupational Therapy Practice**
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<tr>
<td>Author</td>
<td>Jan Miller Polgar</td>
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<td>Title</td>
<td>Assistive technology as an enabler to occupation: What's old is new again</td>
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</table>

**Representation of Social Actors: Named/Classified**

"When the consumer’s perception of assistive technology, the attitudes and behaviour of others, and the institutional context are favourably disposed to assistive technology, then technology should act as an enabler for occupational participation" (p.3); "In the early stages of investigating the choices adults with physical disabilities make with respect to completing occupations" (p.3); "Assistance received from another person or through technology may be viewed by some people as a sign of their dependence and influence the decision to perform an occupation independently" (p.3); "The paradox whereby the use of technology by persons with disabilities is not given the same acceptance as the use of technology in the daily activities of persons without disabilities. Individuals with disabilities who use technology were viewed as lazy or not trying to do all they could to maximize their independence" (p.4); "The attitudes of others are important influences on whether persons with disabilities will accept technology" (p.5); "The behaviours of others can be divided into two categories enabling and disabling. Enabling behaviour of others is evident when their attitude is that the individual who uses assistive technology will continue to engage in everyday occupations...Disabling behaviours are those very behaviours that people with disabilities fear will occur if their disability is visible, as it becomes with the use of assistive technology" (p.5)

<table>
<thead>
<tr>
<th>Disability as a Problem: Semantic Relations and Value Assumptions</th>
<th>In contrast, when it is seen as a visible reminder of disability or limits daily occupation, it becomes a barrier and may be abandoned (p.1); &quot;A young man in the early stages of rehabilitation following a spinal cord injury ‘saw his wheelchair as a dreaded symbol of disability’&quot; (p.4)</th>
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<tbody>
<tr>
<td>Representations of Social Actors: Activated/Passivated</td>
<td>&quot;Our role as health care professionals will be different at different times during the clients' rehabilitation. In the early stages we need to provide much more education and information. We have knowledge that the client has not gained. It is our responsibility to provide this information in a manner that the client can comprehend and at a time that is most appropriate. Later our role is more of a facilitator. When clients are experienced assistive technology users, their knowledge is most likely greater than our own. We should recognize with experience, clients know what works for them, technology or</td>
</tr>
<tr>
<td>Relations of Collocation: Disability/Health/Illness/Dysfunction</td>
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<tr>
<td>“The use it or lose it mentality may influence people to continue to complete an occupation unaided for fear that existing function will decrease” (p.3); &quot;Using assistive technology may be seen as giving up, as not doing all that is possible to regain lost function. AT may be that final indicator for some people that their physical abilities are now different and will remain so for a long period of time. Technology becomes something to be feared because it is a sign of that lost function” (p.4)</td>
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<tr>
<th>Meaning of Disability</th>
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<tbody>
<tr>
<td>&quot;Using assistive technology may be seen as giving up, as not doing all that is possible to regain lost function. AT may be that final indicator for some people that their physical abilities are now different and will remain so for a long period of time. Technology becomes something to be feared because it is a sign of that lost function” (p.4); &quot;Skilled users of assistive technology view it as a tool or as an extension of themselves. They know how it will respond to their actions. In some ways, the technology fades into the background, and its influence on the person’s life becomes invisible” (p.4); &quot;Assistive technology viewed in this manner is seen as a symbol of disability; recognition that life has changed because of trauma or chronic condition. It reflects this young man’s inability to see how he will be able to regain his roles in society and engage with his community” (p.4)</td>
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<tr>
<th>Occupational Therapy Practice</th>
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<tbody>
<tr>
<td>&quot;Our role as health care professionals will be different at different times during the clients’ rehabilitation. In the early stages we need to provide much more education and information. We have knowledge that the client has not gained. It is our responsibility to provide this information in a manner that the client can comprehend and at a time that is most appropriate. Later our role is more of a facilitator. When clients are experienced assistive technology users, their knowledge is most likely greater than our own. We should recognize with experience, clients know what works for them, technology or not, and our purpose may be as an enabler as they seek to incorporate assistive technology in their daily lives. Last and always, our role is to listen and collaborate” (p.6)</td>
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Appendix 4. Three Dimensional Analysis

<table>
<thead>
<tr>
<th>1) Description – What is Disability</th>
<th>2) Interpretation/ Meaning of Disability – What is the language doing?</th>
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<tbody>
<tr>
<td>• Inconsistencies within individual texts re: words to describe (client, consumer, patient)</td>
<td>• Inconsistencies in language within the text: Do these signify a ‘struggle’?</td>
</tr>
<tr>
<td>• Inconsistencies within individual texts re: words to describe (the handicapped, the disabled, people with disabilities, people who have disabilities, disabled persons, individuals with disabilities, people with disabling conditions, people with ambulation disabilities, mental health problems, acquired disabilities, the onset of disability)</td>
<td>• Words also assume individual embodied experience versus a socially constructed phenomenon through social interaction/processes</td>
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<tr>
<td>• Concept of ‘dysfunction’ (occupational dysfunction, illness and dysfunction, fear of decreased function/dysfunction, lifestyle dysfunction, functional independence as key outcome)</td>
<td>• Disability and dysfunction are linked</td>
</tr>
<tr>
<td>• Disability and dysfunction are linked</td>
<td>• Goal of Rehabilitation - Success is measured by increased function</td>
</tr>
<tr>
<td>• Disabled People = Dysfunctional</td>
<td></td>
</tr>
<tr>
<td>• Health and disability; disease and disabling conditions, illness and disability</td>
<td>• Disability $\iff$ Health</td>
</tr>
<tr>
<td>• Prevention of disability and illness, health promotion</td>
<td>• Mutually exclusive categories; assumption that disability cannot be health</td>
</tr>
<tr>
<td></td>
<td>• Therefore, Disability = Ill-Health</td>
</tr>
<tr>
<td></td>
<td>• Health and Happiness are linked</td>
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<tr>
<td></td>
<td>• Disability = Ill-Health</td>
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<tr>
<td></td>
<td>• Therefore, Disability = Unhappy</td>
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<td></td>
<td>• Should work to prevent disability through health promotion</td>
</tr>
<tr>
<td>• Disability as a condition versus disability caused by a condition</td>
<td>• Disability as a condition that causes decreased participation, etc.</td>
</tr>
<tr>
<td></td>
<td>• Therefore, Disability = A process that causes something else</td>
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<tr>
<td></td>
<td>• Disability caused by a condition of the body (i.e., sensory impairment, physical impairment, etc.)</td>
</tr>
<tr>
<td></td>
<td>• Therefore, Disability = A result/outcome</td>
</tr>
<tr>
<td><strong>• Tension between paradigms (models, etc.)</strong></td>
<td><strong>• Explicit acknowledgement of ‘tension’ in profession based on philosophical roots of OT and healthcare system (medical paradigm). Explicit description of the profession being well–positioned for the challenges</strong></td>
</tr>
<tr>
<td><strong>• Holistic approach (person as a ‘whole’)</strong></td>
<td><strong>• Holistic approach explicit in many texts—described as seeing the person as a whole and impacts of environment; however still reference ‘body and mind’ (assuming they are not part of the same ‘whole’)</strong></td>
</tr>
<tr>
<td><strong>• ‘Positioning’ of the profession (‘we are well positioned’) for ‘challenge’</strong></td>
<td><strong>• OT models in Canada have also included ‘spirit’—seen as more ‘holistic’?</strong></td>
</tr>
<tr>
<td><strong>• ‘Coping’, ‘management’</strong></td>
<td><strong>• How do views of ‘holism’ impact our interpretation of ‘the body’? ‘The disabled or dysfunctional body’?</strong></td>
</tr>
<tr>
<td><strong>• Enhancement or improvement</strong></td>
<td><strong>• References to ‘coping’, ‘management’, ‘empowerment’ signal the need to govern disability—the need for ‘self-management’ of disability</strong></td>
</tr>
<tr>
<td><strong>• Disability remains something that is in need of preventing, improving, enhancing (in terms of function)</strong></td>
<td><strong>• Therefore, a negative difference maker</strong></td>
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**Other Language**

| **• “Us” “We” (sets up an ‘us/them’) – used as a rhetorical device that signals ‘belonging’** | **• Other Assumption:** |
| **• One paper described a study, whereby disability was perceived (via interview data) to be a reminder of death and mortality. “Disability brings individuals closer either to death itself or to the idea of death” “A disability may also act as a catalyst for the search to understand the finitude of life in terms of the infinite”** | **• ‘Flow’ = Appropriate skills for the challenge** |
| **• ‘Flow’ = Decreased skill for the challenge** | **• Disability = Decreased skill for the challenge** |
| **• Decrease in Flow = Decrease in QOL** | **• Therefore, Disability = Decreased Flow = Decreased QOL** |
3) Explanation /Understanding – Things made possible, grounds of possibility of OT
talking this way

Larger Social Context:

- Occupational therapy fighting for a position in the healthcare system and within healthcare teams
- Obvious pace of change in Canadian healthcare system
- An increased emphasis on spending in healthcare, requiring the system to ‘prove’ its value and efficiencies
- Healthcare system built on ‘specialization’—breaking the body into parts (or different bodies into categories) and specializing in particular fields (i.e., mental health, hand therapy, paediatrics, etc.)
- The use of ‘tools’ to ‘measure’ in order to provide objective, empirical, epidemiologic data to support funding for services
- 1990s—disability movement
- Government of Canada/Statistics Canada collecting data on disability
- Spending for occupational therapy (not funded in all provincial jurisdictions)
- Since healthcare spending is dependent on provinces—and each province is different (i.e., funding for rehab professionals in BC has always been higher, Ontario’s spending has often been politically driven)—what impact does this have?
- What shifts were happening in 70s, 80s, 90s, 00s regarding disability policy in Canada—did this have an impact?
- Impact of other texts: World Health Organization, Enabling Occupation

Other:

- Large percentage of lectures that met inclusion was given by occupational therapists in Ontario
  - Perhaps because many leaders have been academics, Ontario has the highest number of OT schools/academics?
  - Perhaps because Ontario has the largest number of registered occupational therapists in Canada?
<table>
<thead>
<tr>
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<th>Images</th>
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| 1) **Clinician:** White, woman, young, standing  
  **Client:** White, male, older, wheelchair, pillow and blanket |
| 2) **Clinician A:** White, woman, young, bandana on her head (image of casual clothing), carrying paper, standing  
  **Clinician B:** White, woman, young, hair pulled back (image of professional clothing), carrying clipboard and pen, standing  
  **Client** (same in both sections of image): White, male, similar age, two crutches, mid-stride, wearing a tie |
| 3) **Disablement Model:** White, man, labcoat, clipboard, standing  
  **Enablement Model:** Visual with circle for head and upside down triangle for body (appears as two arms and body/no legs?) |
| 4) **Classic Symbol of Handicap:** Ambulation disability in a box, image shows how OTs work with individuals to minimize disability and environmental constraints to enable living (is living with a disability not living?), final image is that of a tree to symbolize ‘living’ |