

4-15-2010

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Who Owns Disability? An Investigation into the Politics of Representation

by

Shelby Forbes

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
Department of Communication
College of Arts and Sciences
University of South Florida

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Date of Approval:
April 15, 2010

Keywords: Therapy, Expertise, Discourse, Power, Language, Accounts

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Acknowledgments

I would like to thank the members of Appaloosa Farm for allowing me to observe and participate in their sessions, and for giving me the opportunity to work with their organization. I would also like to thank all committee members for their detailed editing remarks. My advisor, Mariaelena Bartesaghi, Ph.D., deserves special thanks for her availability to assist me throughout the writing and editing process.

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ABSTRACT

In this thesis, I show how a community of professionals providing equine therapy to individuals with disabilities discursively make sense of their enterprise. A market metaphor illustrates how disability is constructed as the capital sustaining the livelihood of their industry. Disability is a problem-centered concept. It is generally conceptualized according to a medical model which locates disability within the individual, as opposed to understanding it in a sociological sense which accounts for structural, cultural, and communicative factors. Therapy, on the other hand, is problem-determined—it needs to explicitly determine a problem to be treated in order to sustain itself as an industry and to legitimate the services it provides. As practitioners of an “alternative” form of therapy outside of the dominant biomedical frame, members of this community work not only to validate the need for therapy in general, but also to identify and justify the “uniqueness” of the therapy practiced. In an effort to proprietize disability, these professionals are involved in a politics of representation wherein divergent modes of speaking about disability (i.e., speaking from lived experience, speaking from expertise) vie to represent—or own—disability. In accordance with a market model, members are invested, with stakes in the rights to represent disability. Discourses of development and progress, hallmarks of economic ideology, are applied to bodies by staff as a means to validate the need for their services. Continuing this notion of disability as currency, I will

demonstrate how, through their talk, members of this community construct types of disability—mental and physical—as having higher and lesser exchange values with respect to their therapeutic endeavors. Power too is conceptualized by professionals as a commodity to be exchanged in transactions from therapy-provider to therapy-receiver.

Chapter One

Introduction

As an instructor, I often receive accounts—excuses, justifications, and explanations—from students as to why they have missed class. Recently, I was approached by a student, Grace,¹ who offered an account for her absences. She described to me her required attendance at countless schoolboard meetings, parent-teacher conferences, and institutionally mandated psychiatric evaluations of her son. Grace presented me with attorney’s letters which served as a “factual account” of the school’s assessment of her son as academically “at risk” due to a learning disability. She went on to express her frustrations in her interactions with these professionals. She felt that her testimony of her son’s abilities was disregarded, and she felt that her “voice” in matters regarding her son often went unheard.

Though I had never received this specific reason for a student’s absence from class, it was curiously familiar. After our conversation, I returned to my office to sort through my boxed archives of literature to locate the article where a similar scenario was detailed. The article that I was thinking of was Hugh Mehan’s 1996 discourse analysis of the construction of a learning disability. Much like my student, Mehan found that among three types of discourses used to describe a student, the psychologist’s account (i.e., a medical model) precluded two others: a context-based mode of representation (i.e., a

¹ This name has been changed for purposes of confidentiality.

social model based on the teacher's observations of the student) and a historical one (i.e., lived experience of the student's mother).

After our next class, I gave Grace a copy of the article and outlined Mehan's arguments and findings. I explained that speakers have divergent modes of representing persons, objects, and ideas. The above-mentioned modes—medical, social, and historical—are registers (Halliday & Hasan, 1976) of representation. These registers are distinguishable from one another and from other forms of linguistic representation in grammatical style (i.e., complexity of syntax), degree of formality, and jargon. The types of registers speakers employ are specialized according to the activity being described and the speaker's position with respect to that activity. More importantly, however, I emphasized to Grace that these modes of representation are not only divergent, but also that some discourses are privileged over others. In this way, discourses which construct and represent disability as a "fact" are vying for the ownership of it in a politics of representation.

In this thesis, I employ an economic metaphor to understand this politics of representation and to conceptualize disability as something with exchange value. Disability is the capital which sustains the livelihood of some institutions, including therapy. Therapy is predicated on the existence, identification, and location of a problem—as such, it is problem-determined (Anderson, Goolishian, Winderman, 1986). Disability is a commodity with market value, and it is essential that therapy-providers are the ones to represent disability—to own it—otherwise, their practice is obsolete. To extend this metaphor of disability as currency, I will show how mental and physical disability have higher and lower exchange values within therapeutic settings.

In her 1978 article “‘K is Mentally Ill’ The Anatomy of a Factual Account,” Dorothy Smith likewise employs a market metaphor to explicate her use of the concept of “social organization.” Specifically, she says,

the economic concept of a market which makes possible the analysis of the activities of numbers of individuals buying and selling as a social organization which is unintended by its participants and which produces ‘market phenomena’ as an unintended consequence (p. 24).

Smith’s description of the “unintended consequence” of a market view of social organization is of special import here. In this thesis, I will examine the means by which members of a professional community discursively construct disability and how it functions to legitimize their therapeutic enterprise. In my interactions with members of this community, informants’ rationales for providing therapy appear genuinely altruistic. However, these professionals’ intentions are not necessarily what I am concerning myself with here. Rather, I am, like Dorothy Smith, inquiring into the “unintended consequences” of the discursive operations used by this group to practically make sense of, and organize, disability in therapy.

Over the course of several conversations with Grace I began to relate her experiences with the institutional construction of disability to my own research. For the past 18 months, I have been working with a nonprofit organization, Appaloosa Farm,² which provides therapeutic equestrian services to adults with disabilities. In my interactions as a researcher and volunteer at this facility, I observed processes through the analysis of both talk and text similar to those described by Grace. Much like Grace

² All names featured in this paper, including that of the facility, have been changed to protect the identities of those involved.

discovered, I found that the rights to represent disability and construct it as fact were up for grabs. Each party participating in this contest was to be regarded as interested party, with stakes in the politics of representation. I seek to interrogate the stakes and interests of this community and how they affect members' conceptual organization and presentation of disability and therapy within their interactions. Put simply, my work reveals how the professionals I studied perform their jobs as therapy-providers and maintain the social order which sanctions the therapeutic enterprise. Here I will outline not only the discursive strategies the Appaloosa staff and volunteers employ to identify, construct, and classify a client as disabled, but also their purposes in doing so.

“To *say* something is to *do* something; or in which *by* saying or *in* saying something we are doing something”—J.L. Austin (original emphasis, 1962, p. 12)

Austin's notion (1962) of the performative utterance, in conjunction with Dell Hymes' (2001) notion of the speech act, comprises the theoretical framework for this thesis. Like Austin, I see language as 'doing something.' Therefore, I regard language as constitutive and consequential in relational dynamics of social construction. That is, language creates social realities, as opposed to simply reflecting them. Because language users are actively constructing and shaping their social worlds, Hymes' theory of the speech act is useful to understanding language as having more than just a descriptive function. For Hymes, the speech act asks what the speaker is doing in articulating an utterance in terms of the speaker's pragmatic goals. Pragmatic goals can be understood as the speaker's interests and stakes. More than investigating a speaker's interests though, I am concerned with the means by which they protect their interests from criticism and

negative evaluation. The focus of my research is the strategies informants employ to safeguard their position as therapy-providers and as “experts.”

I will be applying what Karen Tracy (2002) terms a “rhetorical view” of speech which understands talk “as social action” and “communicators as choice makers whose actions could be assessed for practical effectiveness and moral reasonableness” (p. 42). By describing speech as “rhetorical” I wish to convey the strategic and purposeful nature of talk, again underscoring how a speaker’s investment in the subject matter being discussed affects their discursive presentation of it.

To conceive of speech as “social action” means that speakers achieve things in talk. Contrary to any characterization of speech as “just talk,” speakers, through their talk, create, contest, affirm, and reify cultural norms and institutional structures. I will show empirically how talk is social action by featuring instances when, for example, Appaloosa members create social categories to conceptually organize their community, contest categories’ presumed impermeability and the activities associated with them, affirm their status as therapy-providers and “experts,” and reify cultural notions of therapy and disability as both problem-oriented concepts.

Tracy’s assertion that speakers are “choice makers” highlights the notion that they are agentic. While they may be somewhat confined by the limits of language, available to them, are conversational resources which they may employ to renegotiate their roles within interaction, and to reframe the overall presentation of their organization (i.e., its “practical effectiveness”). In the case of the Appaloosa community, an example of a conversational resource invoked by these professionals includes constructing categorical “prototypes” (Lakoff, 1987) to represent the ideal kind of disability, the ideal volunteer,

and ideal account of a therapy session. Categorical prototypes are inextricably linked to issues of morality as they are provided as a “good,” preferred, and socially acceptable representation of the category or phenomenon at hand.

“Moral reasonableness” applies to the third chapter to be featured in my thesis. Moral reasonableness assumes that speakers will offer accounts in the form of examples, personal experiences, and citations of qualifications, when they feel their practices are being assessed. Interviews are an ideal site for moral accounting in that questions, by their very nature, require respondents to work to provide rationales for how they came to their conclusions about the “ways things are.”

My thesis is structured as follows: I have provided a preliminary introduction of the topics to be discussed, and a theoretical frame to contextualize and illuminate my analysis of empirical data in the form of in-depth interviews with staff members, ethnographic fieldnotes, and promotional literature disseminated by this organization. Below, I will background the facility and its espoused objectives. Then I will provide a review of literature in a section titled, “Doing ‘Good’ and Making Sense” on the topics of the interactional construction of dis/ability and the languaging by which the status of “disabled” and “expert” is achieved within a helping relationship such as therapy. In the methods section, I account for my data, analysis, and the methodologies I employ in generating and compiling the data.

The first chapter to be featured in the discussion section is titled, “Organizing the Everyday.” Here, I use Harvey Sacks’ (1992) notion of membership categorization to show how staff members organize types of disability—physical and mental—into a hierarchy. In the third chapter, “Accounting,” I detail a hierarchy of a different kind, one

which is comprised of two types of registers for speaking about disability. In this chapter I analyze the processes by which members of this community secure and validate their industry.

Appaloosa Farm

To get to Appaloosa Farm, I travel to a rural area about 15 miles outside of the major Florida metropolitan city in which I live. About twice a week for the past year and a half, my ill-equipped two-wheel drive car has traversed several gravel roads named things like “Woodstock” and “Crescent.” My journey is marked by a series of ninety-degree turns down a dizzying path. Houses become fewer and far between, giving way to pastures of cows and abandoned rusted machinery. Nearing the farm, my view of the entrance is obstructed by a few inconveniently located pines. I turn into the parking lot featuring an abundance of handicapped spaces.

Adjacent to the parking lot is a red cedar barn with always-fresh hunter green trim. Inside the barn it is a color-coded world. Colors denote what belongs to whom—for example, a purple brush belongs to the horse with a purple name plate outside of its stall. Colors also signify detailed aspects of the day’s schedule on the dry-erase board located in the barn breezeway. Black marker denotes the rider’s name, blue marker matches rider with the instructor, and red marker cautions that the electrical fence is on.

A mulch path leads from the barn to a large, oval arena. The roof of the arena is tin, and under it is a red clay floor littered with balls, hula-hoops, and horse waste. The arena has recently been equipped with several features to make the location more accessible to people with varied abilities; for example, a lifting machine has been

installed in the arena so that individuals with concerns for mobility can mount horses with the ease of any other rider.

A gradually-slanted wooden mounting ramp runs from the side of the fenced enclosure to a patio area complete with picnic tables, plants, and a donation receptacle. On the patio is a free-standing shack for the restrooms, as indicated by the signs “Phillies” and “Colts” (women and men, respectively). Also located outside the restroom entrance is a plaque which reads, “There is nothing so good for the inside of a person as the outside of a horse.”

Past the arena are the lush green grasses of the south and west pastures where client trail rides are conducted. When not used for trail rides though, these pastures cater to the grazing pleasure of the farm’s residents.

Originally founded to explore the physical, psychological, and social benefits of therapeutic horseback riding, Appaloosa Farm is research in action. The program services adults and children with physical and mental disabilities, and has recently demonstrated a special interest in providing therapy to veterans (in part due to the receipt of government funding). Recognizing a paucity of programs tailored to *adults* with disabilities, Appaloosa Farm has incorporated the needs of this population specifically into their mission. In an interview with the organization’s president and founder, Betty Phillips, stresses the uniqueness of her program’s clientele:

so there, there really is a dearth of programs that serve adults with disabilities, and, I mean, even in Alcea County there’s like six other therapeutic riding programs, and they’re all dedicated to serving kids (lines 47-49).

The program is facilitated by paid staff members, and in larger part, by volunteers from community service organizations, local schools, and equine-interested individuals. Appaloosa Farm's espoused objective is to recognize ability within disability. Thus, the instructor, horse, lesson exercises, and volunteer side-walkers³ or leaders⁴ are scheduled in advance with the rider's abilities in mind.

Doing 'Good' and Making Sense: A Review of the Literature

In looking at staff interviews, professionals' interactions with clients, and analyzing this organization's marketing literature, I am investigating a helping relationship. Helping relationships include those between healthcare providers and patients, teachers and students, and therapy-providers and therapy-receivers, to name a few. The helping relationship discussed in this thesis, equine therapy, is what is generally conceived of as an "alternative" therapy as it is considered to be outside of the prevailing biomedical frame.

The first step in examining Appaloosa's helping relationship is to turn to the participants involved and the discursive means by which the staff designate the roles which guide their interactions. The Appaloosa staff is simultaneously creating identity categories for themselves—as able-bodied, as therapy-providers, and as experts—and for program participants—as "disabled" and as therapy-receivers. I will show that these identity categories are transient and permeable. Moreover, I will detail the strategies speakers use to traverse identity categories, identifying differently at times for specific

³ Side-walkers are volunteers who walk alongside the rider applying light pressure to his or her leg, depending on the rider's muscular ability to grip the horse.

⁴ Leaders walk in front of the horse with a lead rope. They are generally used in lessons when the rider's ability to grip the reins is limited.

purposes. One such strategy by which members of this community construct and traverse identity categories is through the process of membership categorization.

Strategies for Identification: Membership Categorization

Category work—the processes of “fitting” persons into social schemata, or “membership categorization,” originated with the work of Harvey Sacks (1972). Sacks asks what goes with what—specifically what activities are associated with what social categories. He terms this phenomenon “category boundedness.”

Membership categorization analysis has been taken up by scholars in conversation analysis and ethnomethodology. It is appropriate and relevant to my work in that membership categorization work is a useful lens for examining how members of Appaloosa Farm make sense of their social world. Specifically, membership categorization makes visible the processes by which these professionals organize and designate the roles of community members as a means to guide their actions (i.e., the category-bound activities associated with each social category). For example, if a member of this community is conceptually categorized as able-bodied, his or her activities are determined accordingly (i.e., this person would be involved in providing therapy, as opposed to receiving it). A caveat to this kind of sense-making though: I will show how the category-bound activity of therapy is reappropriated by informants as an activity associated with the categories of able-bodied members as well as “disabled.”

Carolyn Baker (2004) uses membership categorization analysis in a way similar to how I am utilizing it here. Baker understands interviews as a site for category work. She writes that “When we are asked to speak in some situation, as in an interview for example, we mobilize the resources of available membership categorization devices” (p.

164). As I have asserted, interview settings are prime sites for accounting, and membership categorization is just one of the “resources” available to speakers for producing an account. More than just a resource for accounting, membership categorization analysis is a means to trace “members’ use of these categories and devices...is a means of showing how identities, social relationships, and even institutions are produced” (p. 164).

In Bartesaghi & Bowen’s (2009) analysis of interviews with Holocaust survivors for example, the authors argue that remembering is a category bound activity inasmuch as it is a claim to the epistemic right to memory, or ownership of a first person account. Bartesaghi & Bowen show how memory of the Holocaust is not an automatic right of the survivor, but a matter of discursive negotiation of the survivor category itself in the course of institutional interviews, where first person accounts are granted the status of memory.

Much like remembering, receiving therapy is a category-bound activity. This is because it is tied to access and is achieved by means of a discursive process of authorization. As previously established, therapy is problem-determined (Anderson, Goolishian, Winderman, 1986) and disability is problem-centered. As I will explain in more detail shortly, disability is, in prevailing medicalized representations, a social “problem” located within the individual. Therapy, suggesting treatment or amelioration of these “problems,” is an activity traditionally associated with the “disabled” category as it provides the problem the therapeutic enterprise needs to sustain itself. However, as I have mentioned, I identify alternative uses of “therapy” within informants’ talk.

Category Contingency, Transience & Volatility

By inquiring about the means by which disability functions as an identity category, I am investigating the intersections of disability, identity, and community. This endeavor underscores the interdependency of the identity categories of ability and disability. Both require another (or a *community* of others) to signify.

In their article “Culture ‘as’ Disability,” McDermott and Varenne (1995) emphasize the relativity of ability and disability when they state succinctly, “No ability, no disability. No disability, no ability” (p. 332). Like so many other things (i.e., identity), social categories rely on an other to be meaningful.

McDermott and Varenne (1995) similarly remind ‘us’ of our susceptibility to be ‘them’ when they caution, “Failure is always ready to acquire someone” (p. 344). When the criterion established is put in such broad terms, i.e., “failure” at something, it is easy to understand how any person could be annexed by the ever-volatile category of disability. In other words, if failure at some task is the only requisite for inadequacy, then who hasn’t been relegated to the category of incompetence—of inability?

In another article, “The Acquisition of a Child by a Learning Disability,” McDermott (1993) once more, treats disability as a predatory category. For McDermott, it was not a learning disability that was under investigation, but rather, the rhetoric surrounding disability that allowed for the placement of the child within the “disabled” category. Explicitly, McDermott says “LD [learning disability] is usually assumed to be acquired by children due to some lapse in their development” (p. 271).

This quote touches on several issues immediately relevant to my work. Firstly, the quote expounds upon the notion that a distinction between disability and impairment

should be made; that disability should be regarded as a social phenomenon as opposed to a biological one. McDermott's acknowledgment of the present conceptualization of disability as a biological phenomenon is evinced in the first half of his statement where he says that disability is "*acquired*." "Acquired" emphasizes the biological or medical representation of disability as it suggests that acquiring a disability is comparable to the acquisition of any other biological deficiency, i.e., one acquires a flu virus.

McDermott's phrasing of disability as characterized by a "lapse" further demonstrates popular conceptions of disability as problem-centered. This "lapse" suggests a failure to meet a benchmark of progress, or negligence in satisfying a requisite of development. As I have articulated thus far, therapy is dependent upon disability because therapy, being problem-determined, needs something to "correct" in the form of a disability which is problem-centered.

The reference to development anticipates my later discussion of how the longstanding discourses of development and progress influence how persons regard disability. Therapy is an industry which seeks to develop bodies, and McDermott's reference to development here delineates the connection between discourses of development and disability.

This relationship among disability, identity, and community is further complicated by the notion that an individual holds multiple, simultaneous memberships within several communities and social categories. For instance, if an individual is of African descent, is sexually attracted to women, and possesses some impediment, she may choose to identify with all, some, or none of these social categories. An individual's identities—including impairment—do not organize hierarchically. Moreover, a

“disabled” identity is not the only means for identification. Therefore, it is best to view disability as just one fragment of the self being presented, as opposed to a comprehensive identity that is “given”—to think of disability as an identifying characteristic rather than an (the) identity⁵.

The identity category of “disabled” is fluid. Individuals not only acquire new, diverse categories—categories acquire new, diverse members. In other words, the population comprising the identity category of disability is transitory—the class of individuals who at one moment qualify as “disabled” is not the same group at another moment. As standard cultural definitions for what “counts” as able-bodied and disabled continue to be renegotiated through the terms we use and the words we speak, these categories appropriate new members accordingly (Shakespeare & Watson, 2001).

Shakespeare and Watson (2001, p. 21) comment on this false presumption that impairment presupposes disability as an identity noting,

Any individual disabled person may strategically identify, at different times, as a person with a particular impairment, as a disabled person, or by their particular gender, ethnicity, sexuality, occupation, religion or football team.

“Strategically” is key here, as it recognizes that members are agentive social actors, actively highlighting and downplaying identities within conversation and interaction. Karen Tracy (2001) also depicts interlocutors as purposeful and strategic when she says, “people are crafting their talk to accomplish their aims given the other and the character of the situation” (p. 736). Consistent with this, I will demonstrate how

⁵ Appaloosa Farm founder and president, Betty Phillips, touches on disability as merely one of multiple identifying characteristics in one of her interviews. When asked if and how the way she thinks about things like disability, ability, and therapy have changed since establishing the program she says, “Ya know, so, so I’ve kind of, ya know in my own head, gotten away from thinking about people as disabled or not, or whatever. It’s kinda like yeah, she’s got MS, but her eyes are blue too” (lines 123-125).

certain identities and moreover, certain registers, are strategically offered and withheld—highlighted and downplayed—in informants’ discourse.

Registers of Representation

There are several modes of representation by which social members construct disability in talk. The medical model, which identifies disability as intrinsic to the individual, is one of two primary means of representing incompetence. Conversely, the second means of representing disability is a social model which accounts for more systemic factors. According to Robin Smith (2001) in her essay entitled, “View from the Ivory Tower: Academics Constructing Disability,” the medical model which emphasizes the ‘dis’ in disability, is rendered obsolete by a social model. Disability scholars prefer the social model because it provides for a more ecological view of disability, accounting for societal and structural influences in addition to genetic ones. Like gender and race, an individual’s impairment (a biological construct) is not disabling (a social construct) until society deems it so (Shakespeare & Watson, 2001).

Locating impairment within persons reinforces a principle of therapy which dictates that it is an individual’s responsibility to seek therapy—to seek correction. In interviews with Appaloosa professionals, a medical register or “model” is employed to justify the need for their services. Therapy becomes legitimized through discourses which identify the self as the origin of incompetence and as a site for development.

Despite criticism of the medical model and the institutional framing of disability, many scholars nonetheless note its authoritative presence in representations of disability. For instance, Mary-Pat O’Malley’s (2008) analysis of the institutional framing of disability on an Irish radio program found that radio moderators gave medicalized

discourse preferential treatment functioning to reinforce the portrayal of disabled person as ‘other.’

Evidence of the medical model superseding other modes of representation (such as those of lived experience) is observable as O’Malley (2008) demonstrates in the different introduction of two speakers: one as a “*Doctor* so and so,” and the other as just “So and so” (my italics). This type of introduction grants the medical expert authority to “converse about a medical condition and in this sense is worth listening to” (p. 349). Effectively, authoritative discourse displaces those registers which are incongruent, that is, those typified by the everyday language of experience as opposed to technical jargon.

However, as the speakers in both O’Malley’s (2008) and my study demonstrate, not all passively resign themselves to silence and discursive displacement. In both instances, interviewees (persons with disabilities) engage in “oppositional discourse” to challenge the dominant institutional frame which characterizes disability as “deficit-based” (Smith, 2001, p.57). In O’Malley’s study, individuals used their conversational resources (i.e., their lived experience) to challenge the “status quo” (i.e., the authority of the medicalized institutional frame). Instead of perpetuating the interviewer’s framing of disability as problematic, interviewees describe their experiences with disability as relatively uninhibited.

Appaloosa Farm participant and volunteer Rob Taylor, likewise challenges dominant representations of disability as problematic when says he is grateful for his “disability,” as it has afforded him several opportunities—hardly a problematic characterization.

Ultimately however, in some instances, the conversational resource of lived experience ends up, as the title of O'Malley's article suggests, "falling between the frames" as it is incompatible to a "fact-seeking," medically-oriented register (p. 355).

The Linguaging of Expertise

Congruent with O'Malley's findings, Hugh Mehan (1996) states, that a particular way of representing events in discursive language influences, first of all, the way *we think about* the events represented, and, second, the way *we act toward* the events (original emphasis, p. 274).

If we can agree about the significance of language, then I think it is necessary to demonstrate, as Mehan and O'Malley do, that not all persons have equal access to all registers.

For Mehan, the languaging of expertise, marked by a technical register, "indicates a superior status and a special knowledge based on long training and specialized qualifications" (p. 270). Through the use of technical jargon and explicit references to credentials and accreditations, members of professional communities such as Appaloosa Farm are able to discursively achieve and maintain the status of "expert," and are furthermore, able to validate the need for their services.

In a similar vein, Murray Edelman's (1974) classic article, "The Political Language of Helping Professions" details the function of the specialized discourse of expertise, and it is worth quoting at length:

Because the helping professions define other people's statuses (and their own), the special terms they employ to categorize clients and justify restrictions of their physical movements and of their moral and intellectual influence are especially

revealing of the political functions language performs and of the multiple realities it helps create (p. 296).

The function of language within the helping professions, including therapy, is two-fold: As mentioned above, it serves to construct and validate the therapy-provider's position as expert, and it obscures the politicized interests of the parties involved. For example, as Edelman notes, by classifying an everyday activity as a medical one such as 'therapy' (i.e., sleep therapy, talk therapy), "superior" and "subordinate" roles are established, and "the inhibitions placed upon the subordinate class" are justified (p. 297).

As the literature suggests, language in use becomes an issue of access: Who has access to the esoteric registers of expertise? Are all registers esteemed equally? I will investigate how the languaging of therapy functions within the Appaloosa community.

In investigating the assumptions upon which Appaloosa's therapeutic enterprise is founded, I adopt a position similar to that of Charles Antaki (2006) in "Producing a 'Cognition.'" In this article, Antaki investigates the discursive practices a therapist uses not to discover what his client knows, but how the client comes to know it. In this way, Antaki is concerned with the production mechanisms by which interviewer and interviewee, therapist and client, jointly produce (p. 13) phenomena, specifically, a cognition. Antaki's "Producing a 'Cognition'" establishes the framework from which I operate. He understands interviews not as a site for extracting hidden knowledge contained in the mind, but as a site for co-creating knowledge between researcher and informant.

Also like Antaki, I do not evaluate the therapists' activities in terms of being good or evil, right or wrong, a priori. Rather, I take discursive representations of disability,

power, and expertise as forms of accounting. Accounts, as defined by Karen Tracy, are discursive processes informants employ when their actions are “subject to evaluation” (p.77), wherein informants provide rationales and explanations for their activities. The languaging—or accounting—of expertise is used to validate members’ *raison d’être* as therapy-providers.

It would be far too reductive to assume that the therapy-providers are the oppressors and the therapy-receivers the oppressed—that therapy-receivers (individuals with disabilities) are destined to be discursively displaced and powerless. This is because I engage in empirical work, wherein I make claims from the data as opposed to presupposing them. I view power as a relational dynamic, meaning that it does not reside indefinitely in structures or persons. On the contrary, I believe power to be created, contested, and reified in interaction.

To avoid characterizing power in such positivist and absolute terms, I refer to the work of Klaus Krippendorff (1995). He writes that “power arises in languaging, can be contested in languaging, can be overcome in languaging and is, thus, embodied in the language among real people” (p. 10). This is significant because it recognizes speakers as agentive social actors and as incapable of being power-less. Following Krippendorff’s (1995) observation, I will show how members of the Appaloosa community renegotiate power relations by employing discursive resources and strategies such as the reappropriation of ‘therapy.’

With respect to the social implications of language, I align myself with Krippendorff (1995) and Joanna Thornborrow (2002) who contend that critical theory should be buttressed with empirical data from everyday talk. If critical theory is the only

means for understanding the social world, researchers run the risk of finding exactly what they are looking for and only that. For example, if I already know that power resides in structure A, what is the point of investigation, save to confirm the theory from which I'm operating? Empirical investigations complement critical theory as a way to elaborate upon, depart from, or generate new understandings of "the way things are."

In the discussion section, I will introduce some critical theory to background discourses on development and progress, and will supplement this with examples of how said discourses operate and are made manifest in interaction. Through the introduction of extracts of interview talk, I will show how power is made in interaction, and how informants employ discursive strategies to negotiate perceived status differentials.

Data & Method

First of all, don't worry about whether they're [speakers] are 'thinking.' Just come to terms with how it is that [the detail of talk] comes off. Because you'll find that they can do these things...Look to see how it is that persons go about producing what they do produce (Sacks, 1992 cited in Wetherell, Taylor, and Yates (2001, p. 52).

It is important that I make explicitly clear that I am not adopting a psychological approach to my research. It is not my objective to inquire about what members of this community *think*. Rather, I will interpret informants' talk to make claims about the social order which is simultaneously reflected in, and constructed by their talk. Like Sacks articulates, social interaction is a visible phenomenon—it is visible in the "details of talk".

As such, I treat the interview as a topic for analysis (Sarangi, 2003). From the interview, I make claims regarding the negotiation of identities by researcher and informant, and the institutional framing of the interview setting. One of the discursive devices by which members organize social phenomena is through membership categorization. Membership categorization, as it is used here, is the means by which “identities, social relationships, and even institutions are produced” (Baker, 2004, p. 164). Additionally, I will at times, analyze my own talk within an interview as not only as an act of reflexivity (Alvesson & Skoldberg, 2009), but as a means to further my claims about the social order.

Fieldnotes, five in-depth interviews with six staff members and volunteers (see Appendix A), and promotional literature disseminated by Appaloosa, comprise the data for analysis.

I compiled fieldnotes from visits to Appaloosa Farm usually occurring once a week for four hour intervals (8:00am-12:00pm) over a period of five months. My fieldnotes were compiled while at the site on scraps of paper, and then elaborated upon immediately following the visit. I reintroduced myself to the Appaloosa community as both a researcher interested in exploring the ways in which they “communicate about disability and ability,” and also as a member of the volunteer staff. I say “reintroduced” because I had previously established a relationship with some of the community members, including Appaloosa president and founder, Betty Phillips, when I volunteered at the facility several years ago. I also bring an equestrian background to the research setting (I have been riding and training for approximately 12 years) so many community members constructed my role not only as ‘researcher,’ but also as an “extra set of hands.”

For some of the interviews I came prepared with an interview schedule consisting of relatively general, open-ended questions. However, often this was only referenced initially as a “starting off point,” or not at all. I approached my interviews with a “laissez faire” attitude, allowing the conversation to traverse subjects and topics as they came to the informant or me, producing an emergent interview.

Interviews are speech events (Mishler, 1986) where information is not “extracted,” and where interview questions are not the stimuli that provoke a (more or less desired) response from the informant. Rather, in the process of the interview, researcher and informant are co-constructing meaning, actively working towards shared understanding. Both parties orient their questions and responses in terms of each other attempting to ‘fit’ one with the other (p. 47). Given the interdependent nature of questions and responses, I will not provide decontextualized “sound bites” of interview talk—all responses will be situated in the context of their corresponding question. I engage in interview techniques such as backchanneling or offering minimal responses as a means to show that I am actively listening to the speaker, but also to encourage them to say more.

I digitally recorded and then transcribed all interviews. I transcribe at an intermediate level of detail including in my transcripts vocalizations, nonfluencies, pauses, overlaps, and emphases on words or part of a word. I prefer this model for transcription⁶ because it recognizes the parts of speech which the informant emphasizes via varied intonations and other paralinguistic characteristics. I took few notes during interviews, however I used my fieldnotes to contextualize interview data.

⁶ The transcription model used in my research is comparable to those of conversation analysis in that it emphasizes how questions and answers work together sequentially to in order for claims to be made, sustained, and contested. See Sacks, Schlegoff & Jefferson (1972).

My objectives for this thesis are dual. In addition to interrogating the speakers' purposeful aims in their languaging of dis/ability and therapy, I am also attempting to bridge critical theory with social interaction. In doing so, I must make a distinction between "discourse" as theory and "discourse" as a methodology—what is known as "big 'D'" and "little 'd,'" respectively (Gee, 1999). Big 'D' is comprised of theoretical and institutional metanarratives. In the case of my research, for example, when I refer to discourses of development as they relate to therapy, I am speaking of 'big D.' Little 'd' on the other hand, is discourse as it appears empirically in interaction—here, in utterances of interview talk and textual data.

The Appaloosa literature featured in this paper was given to me by an informant at the close of an interview as a means to further explicate the program she was describing. This exemplifies the interdependent relationship between talk and text. Text is sedimented talk, an institutional documentation and presentation of the ideal self—or in this case, the ideal enterprise.

Much like the legal documentation my student presented me with in the opening account, documentation of the kind featured here functions as an indexical tool. Informants refer to the organization's literature as a source of disembodied expertise by which they can guide, explicate, and authorize their therapeutic practices.

The promotional literature analyzed here is generally marketed to corporations, military personnel and veterans, and individuals for whom "traditional" avenues of therapy have proved unsuccessful, or those who seek "self-exploration and adjustment" (Appaloosa Farm E.A.S.E. program literature, p. 1).

Chapter Two

Organizing the Everyday

Disability as Mental and Physical Categories: A Professional Hierarchy

My interactions with Appaloosa professionals were foregrounded by one research question in particular. How do members of this community practically make sense of their enterprise? In interview talk, Appaloosa professionals refine the category of disability into two subcategories, physical disability and mental disability. These categories however, are not symmetrical. Rather, the categories of physical disability and mental disability are spoken of in terms of a hierarchy, with physical disability being preferred over mental disability by Appaloosa staff. Their talk suggests that as a participant receiving therapy in their organization, it is better to be physically “disabled” as opposed to cognitively “disabled.”

In two separate interviews, informants Emily and Robyn, both Appaloosa professionals, describe a rider’s mental aptitude as a “saving grace” for his or her physical limitations. The formulation for talk of this nature goes something like this: “Well (s)he can’t do this because of (name the impediment), but mentally (emphasis added), (s)he is fine.” This formulation may be observed in Emily’s account of a rider, John:

- 87 R: Um, so ya know, about changing minds, in what ways, if any, has
88 your experiences here influenced the ways you think about things
89 like disability and therapy—do these things mean the same things
90 to you um, now as they did prior to your coming here?
(...)
105 I: ...I think, coming out here I guess, has kinda opened my eyes how

106 much being in this type of environment and being um (1.0), with
 107 horses—how horses can help disability people.
 108 R: Mm-hm.
 109 I: N how they can help ya know, veterans with ya know PTSD, and
 110 different suff. N how much of an influence it can really have on
 111 someone. Um, I dunno, have you been a part of one of John
 112 Calhoun’s lessons? The, the marine who—
 113 R: No.
 114 I: He was the—he’s a ex-marine—I’m not quite sure how old he is, if
 115 I had to guess I’d say somewhere in his thirties. Um, but he had an
 116 ID blow up n he lost half of his br[ain
 117 R: [Oh my gosh.
 118 I: N then um, he can, he can function like he knows what’s going on
 119 around him. Um, he can’t walk very well. Like some of his ya
 120 know, physical funct[ioning
 121 R: [Mm-hm.
 122 I: isn’t, ya know, a hundred percent. But um, he knows what’s going
 123 on around him...

True to form, Emily’s account of John describes his physical shortcomings, yet she qualifies and mitigates them with the word “but” in line 122, and with the subsequent testimony of his cognitive ability thereafter. By employing this contrast structure, Emily’s pairing of physical and mental (dis)abilities implies a hierarchal relationship. She uses testimony of John’s cognitive capability as a redemption suggesting that mental capacity, being the more important quality, trumps the physical. The contrast Emily sets up between types of ability in lines 118-123 functions to salvage John from social disfunction as she attributes him with the kind of ability (mental) that is more the valuable social capital.

Through her speech, Emily naturally adds emphasis to ‘mental’ (line 142) and ‘physical’ (line 120). Thus, the speaker distinguishes the subcategories of physical and mental (dis)ability as separate. Yet by using them in conjunction, she constructs a hierarchy in which physical disability (as opposed to mental disability) is more esteemed.

When asked about what her participation in the therapy sessions provides to her

personally, Emily, as an able-bodied staff member, speaks for society in her ability to assess John's disability:

18 I: It's just, just being in this environment—and that's one thing *I can*
19 *definitely say for the disabled individuals*, that it just, it kinda
20 relaxes your mind. N it just kinda helps ya calm down and filter
21 out, ya know, your thoughts, n, n everything. N that's, ya know,
22 kinda relates to *the disability people* where *they* are more open to
23 try new things or um (...)

By speaking “for” individuals with disabilities (lines 18-19), Emily is presenting herself as able-bodied, as a member of the category ‘us,’ which is qualified to evaluate the social category of “disabled,” of other, of ‘them.’ The implications of Emily’s speech are great in that by differentiating John’s disabilities and abilities and organizing them into a hierarchy, she is prescribing how he should live according to the social strata in which she has discursively placed him.

This format of first speaking of physical disability and then immediately following with testimony of cognitive *ability* is likewise exhibited in Robyn’s (I1) story about a rider, Kate:

1 R: Can you think of any (2.0), any stories that you know, you might
2 have from your experiences here that have kinda stuck with you,
3 that made a big impression on you or anything like that?
4 I1: Impression...
5 R: Anyone you worked with that you know, made a lot of progress or
6 um (1.5), I don't know, I'm just trying to think of stories
7 particularly.
(...)
20 I1: 'Kay, there used to be this girl, there was uh a couple, a, a older
21 couple who used to bring their daughter Kate. And they were
22 Gene and Barb.
23 R: Mm-hm.
24 I1: And they would ride themselves. They used to bring their daughter
25 Kate, who was probably in her thirties, late thirties at the time, who
26 um I think she had a baby, and after she gave birth she had a stroke
27 shortly after.
28 R: Ohhh.

29 I1: So she—her vision, she'd always say she couldn't see. And you
30 could tell mentally that she still had, had a couple things going on.

Like Emily's account, Robyn's follows suit by first describing the rider's physical deficiency and then offering a compensatory description of her mental status (lines 29-30). The difference here however is that the hierarchal relationship of these two qualities is not as obvious in Robyn's use of them; for instance, she does not use a word like 'but' or 'however' to qualify her account of the rider's disability as Emily does. The order in which the descriptions of physical and mental (dis)ability is presented though, makes the hierarchy implicit and nonetheless present. Robyn first speaks of the rider's physical disability and then couches and situates it with subsequent testimony of cognitive *ability* ("mentally" is emphasized in line 30). And though having only "a couple things going on" is hardly considered praise, it is still acknowledgement of ability as opposed to disability.

An interesting phenomenon is occurring in both Emily and Robyn's interviews. Both individuals offer exemplary stories of participant prototypes (Lakoff, 1987) to do the work solicited by my question, and to make sense of their practices. Within these interviews, both participants, John and Kate, serve as prototypes representative of the category of "ideal client." As I have shown, this category is typified by a physical disability as opposed to a cognitive one. These participants are also prototypical in that prior to an event which caused their disabilities, they were engaging in socially "productive" activities with their bodies: John contributed to society via his military service, and Kate, by giving birth. Before the tragic events that contributed to their disabilities, these participants were socially valuable for their productive societal contributions. By attributing them with social capital in the form of mental ability,

Appaloosa professionals are attempting to construct these participants as socially valuable once more.

In an earlier paper on my initial work with the Appaloosa community, I titled the piece “Making the Invisible Visible.” Visibility, as it relates disability, is inextricably bound to the therapeutic enterprise; before therapeutic intervention can occur, a professional evaluation of the “problem” (i.e., the disability) to be treated must take place first. Mental disability proves difficult for the therapeutic intervention by Appaloosa professionals because the limits of the “problem” or disability cannot clearly be demarcated. By privileging physical disability in their interactions, Appaloosa participants are favoring the kind of disability which is perceived as most responsive to their therapeutic practices.

What is more, is that the contingency of the categories of ability and disability, physical and mental, is underscored by the informants’ interview talk. These categories (ability/disability, physical/mental) are not presented without explicit reference or at least allusion to its counterpart. These findings thus provide support for the popular assertion made by much of the extant literature on the subject which contends that the social categories of ability and disability are valued in relation to each other. In other words, it is the tension that exists between these two categories which makes them meaningful.

The Reappropriation of ‘Therapy’

By asking the question, “What criteria must one meet to qualify him or her as a member of the disabled or able-bodied class?” I am adding another dimension of complexity to the membership categories of dis/ability. For some, it may be tempting to identify those members of the Appaloosa community who *receive* therapy as members of

the disabled class, and the *providers* of the therapy as representatives of the able-bodied class since “therapy” is a category-bound activity typically reserved for “disabled.” The logic implicit in helping relationships (Edelman, 1974) argues something similar—that the individuals who “help” are also those who are “able” to help. Enticing as such logic may be, much of what appears in members’ interview talk proves this to be reductive and false.

In his 1972 “On the Analyzability of Children’s Stories” Harvey Sacks outlines the notion of category-boundedness as it pertains to membership categories. Sacks employs a generative view of language wherein the noun (i.e. mother, baby) evokes an “appropriate” verb or category-bound activity (i.e., “picks the baby up,” and “crying,” respectively). For Sacks, the category-bound activity of “crying” is inextricably linked to the social category of “baby,” and the category-bound activity of “picks the baby up” goes with the category of “mother.” Sacks analyzes the statement “The baby cried. The mommy picked it up” as an exemplar of category-bound activity for the reader can infer that it is the baby’s mommy who picked it up as the activity itself is bound to the category of mother.

The concept of category-boundedness is integral to understanding the reappropriation which occurs through informants’ talk. Typically, therapy is a category-bound activity which is associated with the category of “disabled,” implying an asymmetry wherein only members of the “disabled” category are the receivers of therapy. However, members of the Appaloosa community use “therapy” as an activity in which able-bodied volunteers participate, in addition to riders with disabilities.

Across several of the informants' interviews, there are marked references to the needs of staff being met via their participation and membership within the Appaloosa community. When questioned about a comment she previously made concerning staff and volunteers satisfying their own needs via therapy, Betty Phillips, Appaloosa president and founder, cites the following motives for their participation: the "genuine" desire to perform community service, atonement for some "sin," and diversion for those who are in between jobs or do not work. The most noteworthy aspect of Betty's contribution, though, is what follows. She says "...there's something really therapeutic about helping other people" (line 33). Here she has appropriated the term 'therapeutic,' which is traditionally reserved for or associated with the disabled class, and used it in reference to able-bodied persons. As a result, she has refuted any line of thought which dictates that the receipt of therapy 'goes' (to use the language of Sacks) with the membership category of disability exclusively, and vice versa.

Similarly, in the course of interview, Robyn (I1) and Maria (I2), recount their own reasons for volunteering at the farm and speculate on the reasons of others. Many of the reasons proffered overlap with those listed by Betty; these include filling idle time and providing a distraction amidst emotional turmoil. Also congruent with Betty's interview, is the same alternative use of the word "therapy" used by Robyn:

(...)

- 25 R: Um, so you do think—what kind of needs do you think are
26 met by the staff and volunteers?
27 I1: Um, I think maybe one thing, sometimes you get people who may
28 be lonely, um don't have a lot of you know, social network, family
29 to rely on. And they come out, and they ride the horses, and you
30 get to know them, and I think we become their frien[ds
31 R: [Mm-hm.
32 I1: too. And they kind of use it as a psychological therapy, you know
33 they can tell us their problems...

By reclaiming ‘therapy’ for ability *in addition* to disability, Appaloosa professionals are further blurring conceptual boundary lines.

In a later interview with Betty Phillips, she acknowledges the limits language imposes upon her. Betty articulates that though she does not subscribe to binary views of ability and disability, she is forced to use these terms for “ease of conversation” (line 16):

- 6 R: Um... I guess one of the major questions that I’m kinda running—
7 that keeps coming up in my mind like while I’m here n when I go
8 home and do journal entries, um, how has the way that you think
9 about, uh, concepts like disability and therapy—has that changed
10 at all, like, with your experiences here prior to your establishing
11 this facility?
12 I: (Indiscernible talk)
13 R: Or, has it stayed the same?—Or...
14 I: Um, ya know, I kinda gotten to where (1.5) in my head and in my
15 heart, I really don’t (1.0) look at people as disabled or able-bodied.
16 I use those terms more for ease of conversation...

So what is to be done? Are speakers without agency when it comes to matters of linguistic paradoxes? I argue, as does Karen Tracy (2002), that speakers have resources available to them to (re)negotiate the entailments of their linguistic choices. Resources of are conversational devices which allow speakers to gain the turn to talk, to provide a compelling account of a phenomenon, or to construct themselves as a reputable source.

In the introduction, I described my student’s dealings with her son’s school, and her presentation of attorney letters. This documentation serves as a conversational resource for my student in that she is able to refer to an external source, a “factual account” (Smith, 1978) in which her son has been historically constructed as disabled, and she is furthermore, better equipped to account for her absences.

The resource being discussed here is reappropriation, wherein Appaloosa informants reclaim a term. In the case of the Appaloosa community, professionals (re)associate an activity traditionally reserved for one population (i.e., “disabled” population) with another (i.e., able-bodied).

When asked about what the program provides to the able-bodied volunteers, Betty

(I) continues:

- 82 I: Um, ya know, it’s occurred to me over the years that, that people volunteer
83 for a variety of reasons...
- 84 R: Mm-hm.
- 85 I: And some people are, are genuinely looking to perform community
86 service...
- 87 R: Mm-hm.
- 88 I: Now there may be some interesting reasons behind that. Ya know, maybe
89 there’s some (2.5) sin they’re atoning for. Or, or maybe they’re just civic-
90 minded and, and high on that Maslow’s hierarchy of ne[eds
- 91 R: [Mm-hm.
- 92 I: and feel like that’s something that they should do to be a good person.
- 93 R: Yeah.
- 94 I: Or simply because it’s the right thing to do—to give back to your
95 community.
- 96 R: Mm-hm.
- 97 I: But, you get all kinds of other people out there that are in transition (1.0)
98 places in their lives. They’re divorced recently, and they’re lookin’ for
99 company, ya know, hopin’ to meet new friends and make a new social
100 circle
- (...)
- 115 I: Um, and then other times, um, they’re between jobs.
- 116 R: Mm-hm.
- 117 I: Um, and looking to fill some time. Or they’re (1.0) lonely, um... We’ve
118 got a few women whose husbands work and they don’t.
- 119 R: Mm-hm.
- (...)
- 122 I: But I think also, it’s the culture out at the farm too that people like. That—
123 it’s always healing to help others.
- 124 R: Mm-hm.
- 125 I: Ya know? And no matter what you got going on in your life, whether
126 things are good or not so good, or just okay, there’s something really
127 therapeutic about helping other people.

Specifically, I want to draw attention to the very last line, 127, where “therapeutic” is used to describe the participation of able-bodied volunteers. Reappropriation of “therapy” is a reoccurring theme addressed by several informants across several interviews.

The consequences of reappropriating ‘therapy’ in this way are profound. The notion of therapy is traditionally predicated on a strictly asymmetrical practice, with the therapy-provider exclusively imparting the expertise and instruction for engaging in therapy, and the therapy-receiver, exclusively participating and receiving therapeutic benefit. However, as exemplified by Betty’s talk, therapy is redefined as a non-expert practice wherein volunteers are simultaneously facilitating and receiving therapy. Betty’s talk also constructs therapy as an ideally temporary phenomenon, specifically, as a transitory life phase (line 97).

By speaking of therapy in this way, Betty’s speech invokes a discourse of progress and development historically tied to the institution of therapy. Betty’s speech indicates an assumption that once a participant has achieved the status of “developed,” or has demonstrated sufficient “progress,” the therapeutic intervention can be determined successful and is thus, no longer needed. In other words, therapy exists as a temporary service.

In my later chapter on accounting, I detail how notions of development and progress function in Appaloosa’s marketing literature. Contrary to what is occurring in Betty’s interview, I cite critical theorists Theodore Adorno and Max Horkheimer who argue that it is impossible for individuals to ever attain the status of “developed.” By regarding development as a vanishing horizon, I illustrate how this particular discourse

ensures the livelihood of the therapeutic enterprise in that bodies are never “developed,” and bodies continue to provide the “problem” therapy needs to survive.

Although Betty presents therapy as a symmetrical practice, inherent in the interview and the symmetry is a hierarchy. I used Lakoff’s (1987) notion of prototype to explicate my discussion of the categories of mental and physical disability as a hierarchical constructs. Here too, the concept of categorical prototypes is useful to understand Betty’s construction of the ideal or *prototypical* volunteer. In lines 82-85, Betty creates a contrast between the volunteers who participate for a “variety of reasons” and those who are “genuine.” This contrast is founded on the assumption that some of the volunteers’ purposes for participating are not “genuine,” and Betty, as an “expert” is qualified to discern the difference. Thus, the appearance of symmetry itself is not genuine in that it is internally hierarchical; though there may be a semblance of symmetry between volunteers and participants, within the category of volunteers itself, there is apparent asymmetry.

Appaloosa staff member, Cherry, also addresses therapy in terms of a transitory life phase (lines 62-64), and she identifies another party (line 52) receiving therapeutic benefit from the program in addition to the able-bodied volunteers and participants with disabilities previously described.

- 045 R: Mm-hm. Do you find em talking—try—like, do you find that a lot of the
046 people that come out there are, are coming out there ALSO for the social
047 aspect then? Talking to you a lot...
048 I: Yes, yes, yes, yes. Talking about things that they do or things that they
049 have done, or ya know, something they saw on TV, something they’re
050 doin in school
051 R: Mm-hm.
052 I: Yeah, I do. I think a lot of it, and a lot of it is, is social for their caregiver
053 as well because they get to (1.0) relinquish care for just a few minutes n

054 sit back n read a book or
055 R: Yeah.
056 I: or whatever. So it benefits both.
057 R: Um (2.0), well I was thinking that—one of the things I’m thinking about is
058 you know (1.0), there’s the obvious needs being met of the riders, but I
059 I think a—you know, I’m starting to realize that a lot of the volunteers and
060 staff are meeting their needs like you said. Um, do you see that a lot with
061 the uh other staff and volunteers?
062 I: I do, I do. It seems to be that a lot of volunteers we get are at an odd place
063 in their life. Uh, they’re either in between uh jobs or (2.0) just left a
064 relationship, a long- term relationship, n they’re just looking for
065 something to (2.0), something to do, something physical to do to take their
066 mind off it. Um, it also is a, is a good way to give back. It’s something that
067 people can do. They don’t have to give financially, they can just give of
068 themselves and give their time and it really is, a a good, a good feeling.
069 R: Yeah.
070 I: You—you get just as much, I think, out of it as the riders do.
071 R: Mm-hm.
072 I: You make a lot of good friends out there.
073 R: I know, I know. Really.
074 I: Good, good group of people.

By identifying participants’ caregivers (lines 52-56) and able-bodied volunteers and staff (lines 62-68) all as parties receiving therapeutic benefits, Cherry is interactionally renegotiating the category-bound activity of therapy as strictly an activity for “disabled” persons.

Reappropriation is predicated on language-in-use. In her text, *Feminism & Linguistic Theory*, Deborah Cameron (1992) resists subscribing to a strictly deterministic view of linguistic differences between men and women as a means to explicate women’s social inequities. She advocates changing meanings of words through changing how they are used, focusing on what semiotician Ferdinand de Saussure (1986) has popularized as the “parole” function on language. Language-users can act to alter their social realities by “taking back” or reappropriating words and changing their meaning in talk in interaction. Cameron illustrates the concept of reappropriation through the introduction of the

pejorative “dyke.” In her discussion, she details how some lesbian feminists have reappropriated this word in their interactions by using this term as a positive label. To change the implications of language in terms of the realities it creates, one must direct attention not to how it operates out of context, but rather, to how language functions as talk in interaction.

I argue that the reappropriation performed by Appaloosa members through their talk resists constructing individuals with disability as ‘other’ as they shift “therapy” from an activity for the ‘other,’ and use it to describe their own participation within the program. This reappropriation however, is a dual-reappropriation in which therapy is applied to persons with disabilities, but also to volunteers, specifically a certain sect of volunteers. As exemplified in her interview, Betty applies therapeutic benefit to those volunteers whose purposes are “genuinely” altruistic, and whose participation is not temporary. Therapy is reappropriated as a category-bound activity for prototypical volunteers—“good people”—whose purposes qualify them as proper ministers of therapeutic services.

Chapter Three

Accounting

In this chapter of my thesis, I investigate speakers' accounting work, or the offering of rationales as a means to explicate, justify, and make sense of their professional work. Accounting, as previously discussed, occurs when speakers provide explanations for their practices when they perceive them to be under evaluation (i.e., in an interview setting, Lyman & Scott, 1989). Regarding how accounts function discursively, Richard Buttny, in his 1993 text *Social Accountability in Communication*, outlines several aspects of the accounting process, three of which I believe will be especially instructive here. First, Buttny claims:

Accounts involve talk designed to recast the pejorative significance of action, or one's responsibility for it, and thereby transform others' negative evaluations. This *transformative function* is the most distinctive feature of accounts as a *discursive practice* (original emphasis, p. 1)

Secondly, Buttny describes accounts as a prime means for excavating implicit cultural knowledge about "taken-for-granted assumptions" (p. 2), and for making it explicit.

Lastly, Buttny contends that while most persons, as members of a culture, are held responsible, or accountable, for such assumptions and are taken to be versed in folk knowledge, some individuals remain exempt from accountability. These excluded individuals are children or the disabled. This lack of accountability, he points out, is

indicative of the “individual’s status or category of personhood—as a not yet competent member or adult” (pp. 3-4). As I have previously argued, Appaloosa professionals as “experts” are held accountable to speak for those whose status as members of the disabled category renders them “incompetent” to account for their experienced knowledge of disability.

Buttny’s summary illustrates the strategic and purposeful nature of accounting. Speakers utilize this discursive operation to, as he says, “transform” potentially negative evaluations of their practice into positive ones. In this section, processes of accounting include providing experiential testimony, explicitly citing credentials, qualifications, and affiliations. It also means locating impairment within the individual as a means to safeguard Appaloosa’s therapeutic practices from possible scrutiny.

Speaking (of) Categories: Authority of Experience and Authority of Accreditation

Within interview talk, two means of categorizing authorization were employed by Appaloosa staff: the authority derived from lived experience, and that which is conferred through institutional degrees and statuses. Different informants and different conversations give preferential treatment to both modes, strategically employing the discourse as the situation and other calls for it.

Within the Appaloosa community, speakers imply a simultaneous esteem of both authorities of experience and authorities of accreditation. In light of such practices, one is reminded that the realities of this community are not constructed in irreconcilable absolutes with one type of authority being valued more consistently. Rather, through their speech, members move back and forth between these two poles of authority.

Rob Taylor, both a participant receiving therapy for his multiple sclerosis (MS) and a staff member on the board of directors, discusses the ways in which he has been sought out for his lived experience of MS. Rob's firsthand knowledge of his disability and the treatment (therapy, pharmaceuticals) of it, make him a highly desirable spokesperson for several parties, including: Appaloosa president and founder Betty Phillips, pharmaceutical representatives, and fellow MS patients.

When asked about his experiences as *both* a volunteer and a participant, Rob recounts different instances (fundraisers, publicity events, city council meetings) when he was solicited to speak on the organization's behalf. Additionally, when asked if he thought that his unique position afforded him a certain degree of credibility, Rob (I) agrees enthusiastically and then proceeds to compare his experiences as Appaloosa spokesperson to those as a "grassroots" representative for pharmaceutical companies:

- 1 R: Um, so do you think there's some level of um (2.5), credibility
2 because you are participating?
(...)
5 I: Oh yeah.
6 R: So you can testify firsthand?
7 I: Right. I mean it's (2.5) like with—well I'm also um (1.0) a patient
8 advocate for a drug comp[any
9 R: [Mm-hm.
10 I: called Paxin (?)—type of neuroscience.
11 R: Mm-hm.
12 I: And also for Medtronic, for the pump.
13 R: Uh-huh.
14 I: And (2.0), when I'm talking with people, I don't really think of it
15 as you know, putting myself out there. But then my reps, the drug
16 reps, ((indeterminable speech)), the pump reps. You know, they'll
17 be like, 'We can stand up there and talk (1.5) about everything the
18 pump do[es
19 R: [Mm-hm.
20 I: but having you be there (2.0) is more important—almost more,
21 more important than what we say.'
22 R: Why do think that is?
23 I: Well it's because people are looking—you know (1.5), they're

24 always sorta (1.0) jaded. Especially, you know, with—and I’ll say
 25 from an MS perspective, they’ve heard so many drug reps...
 26 R: Mm.
 27 I: telling this does this, this does this. But if they can hear somebody
 28 who is actually on the, the drug (1.0), it holds a lot more weight.
 29 R: Mm.
 30 I: And Betty, with here, Betty is very conscious to—and it may not
 31 always be me—
 32 R: Uh-hm.
 33 I: but, of putting forward (1.0) the riders. Well you know, when
 34 people ask to come out to do newspaper...
 35 R: Mm-hm.
 36 I: or TV, or whatever. She is going to (1.0) put the participants first.
 (...)
 42 I: She’s more focused on letting people see that there are real people
 43 here...
 44 R: Mm-hm.
 45 I: that are being affected in a positive way.

Rob’s speech identifies a desire for his authority of experience from three parties (categories of authorization): the pharmaceutical reps (lines 14-17), fellow MS patients (23-28), and Appaloosa president and founder Betty Phillips (lines 30-43).

However, although the last of these parties mentioned, Betty, is represented in Rob’s talk as a proponent of an authority of experience, she appeals to a contrary model within her own interview. When asked how the facility came to be, Betty describes the steps she took towards establishing the program, including getting her Ph.D. She concedes that although obtaining her doctorate was not necessary, she believed it helped grant her and the program a degree of credibility with respect to donors and grant administrators (lines 28-29). Additionally, later in the interview when asked to describe the fundraising workshops the farm conducts, Betty expresses excitement about Appaloosa’s affiliation with the university. She says, “Yeah, not to mention, that we’ll have the credibility of U of X” (line 163). Thus, through her talk, Betty has constructed

an associative relationship between the word ‘credibility’ and institutional representations of authority (i.e., a degree, the university).

The difference between Rob’s portrayal of Betty as a champion of the authority of experience and that which is valued within her own talk (an authority of accreditation) may be accounted for by noting that Betty’s speech implies an external pressure. For instance, her first comment about getting her PhD may be interpreted as her estimation of the kind of authority valued by others, specifically donors and grant administrators. Though Betty may be engaging in what O’Malley (2008) terms “oppositional discourse”—discourses of experience, discourses which challenge the “status quo”—within her community, this community nonetheless exists within a larger social milieu. And as recent studies suggest (O’Malley, 2008; Mehan, 1996), this social milieu is dominated by a medical model wherein institutional discourses reign supreme.

“Alternative” Therapy as Accountable Other

The equine therapy practiced at Appaloosa is what is generally conceived of as outside the dominant biomedical paradigm consisting of exercise therapy, psychotherapy, and talk therapy. Aware of the status of equine-assisted psychotherapy (EAP) as “alternative” or ‘other’ within the prevailing biomedical model, informants do accounting work (including employing registers typified by references to accreditations or firsthand testimonies) to legitimize their therapeutic practices.

Libby, Appaloosa’s weekend barn manager, acknowledges the therapy practiced at Appaloosa exists outside of the prevailing medical model when she contrasts the equine therapy featured at the facility with more “conventional” therapies such as talk therapy:

154 R: What is the um (1.0), the talk therapy that you were contrasting this kind
 155 I: MM.
 156 R: and you're like, 'this is not talk therapy,' what is that?
 157 I: Well you know like when people say like, 'I go to counseling'?
 158 R: Mm-hm.
 159 I: Or 'I—I go see a therapist'? And they—or you think of the typical shrink
 160 R: Mm-hm.
 161 I: Um, of layin on a couch
 162 R: Mm-mm.
 163 I: Ya know, and you talk out your problems
 164 R: Mm-mm.
 165 I: And they say, 'Well, why'd you do this? And why did...' It's not, it's not
 166 about that.
 167 R: Okay.
 168 I: It's not about talking, it's about using the HORSE as a professional. And
 169 it's about the person experiencing something with the horse.

Libby recognizes her therapeutic practices as different from a “traditional” form of therapy, i.e., talk therapy, in lines 168-169 specifically. This strategy sets up the accounting work she does later in the extract where she positions herself as a participant in talk therapy as a client recovering from an eating disorder (lines 190-191). By disclosing her involvement in talk therapy, she is removing personal accountability and attributing herself credibility when she criticizes it in this extract in lines 160-161, 163, and 164. Within these lines, Libby constructs talk therapy as a passive endeavor (i.e., “layin on a couch,” line 161) where clients talk out problems (line 163). Libby’s speech is predicated on a pejorative characterization of talk as ‘just talk,’ as without consequence, or more importantly, without result. This same stereotype of talk therapy is present a few lines later in lines 220-225. Once more, Libby portrays talk therapy as passive (“sit there,” line 221), and as not progressing towards a purposeful outcome (“blah, blah, blah,” line 221):

186 R: What do you think each provides? Wh-that maybe the other doesn't? So
 187 what do you get out of talk therapy and what do you think—I know it's

188 hard to say what others get out of EAP, or what, what do you get out of
189 EAP as a facilitator?
190 I: Yeah, well I mean, I can a—I kinda did EAP on myself. Um, I’m
191 re-recovered from an eating disorder.
192 R: Mm-hm.
193 I: And my first year that I my, the five months that I worked here before I
194 left for school, I was in outpatient treatment
195 R: Okay.
196 I: So during the week, um, four days a week. So I was kinda doing EAP on
197 myself in a, in a, in a sense.
198 R: Mm-hm.
199 I: In a very broad sense of the term.
200 R: Okay.
201 I: Um, I was playing with the horses, I was doing things, I was doing natural
202 horsemanship, I was learning how to communicate with the horses which
203 was helping my communication. So I think that th-the difference for me,
204 between the talk therapy, was that a lot of times when you go into EAP,
205 you’re not aware that there’s an issue. Some people have that problem
206 when they go into talk therapy, but more so, in my opinion
207 R: Mm-hm.
208 I: in EAP you’re not aware that there is an issue, or that there’s any deeper
209 issue.
210 I: Okay.
211 R: You think that it’s just that you can’t communicate.
212 R: Mm-hm.
213 I: Well, that’s not really an issue. It’s why can’t you communicate?
214 R: Mm-HM.
215 I: Is my—what I wanna know
216 R: Underlying cause...
217 I: What d—why do you think you can’t communicate? Wha-what do you
218 think the reason is?
219 R: Mm-hm.
220 I: Ya know, the underlying cause. But in talk therapy you sit there and you
221 talk about all these things, and ‘I can’t communicate, and blah blah blah.’
222 And you know the per- and my therapist she’ll take notes, n um, she’s a
223 Christian counselor, and she’ll say ya know, ‘Well I know—I keep
224 seeing—I keep hearin you say this same thing over and over again. I
225 don’t, I don’t understand why you’re saying that. Ya know like?’

Though Libby sets up a contrast structure between traditional talk therapy and EAP by outlining their differences and talk therapy’s shortcomings, at the same time, she reinforces the principles of traditional psychotherapy as a means to validate her own therapeutic practices. In lines 208-209, she mentions that EAP is instrumental in that it

gets at an underlying issue. Traditional psychotherapy such as talk therapy is predicated on this notion of an underlying, hidden, invisible issue. Capitalizing on popular conceptualizations of the mind as a container (Potter & Puchta, 2007) which holds concealed information, the therapeutic enterprise positions itself as expert asserting that with the intervention of the therapist or therapeutic practice, this clandestine information may be extracted, made visible, and in turn, “corrected.”

Related to the notion that an expert is necessary to identify the “hidden” underlying issue, Libby identifies the participant as entering the therapeutic setting with a problem (lines 204-209), effectively designating the origin of incompetence with the individual and not necessarily his or her therapeutic interactions. She validates the need for her enterprise as she constructs the individual entering the therapeutic encounter as initially and potentially unaware of his or her “problem” (lines 205-209). What Libby’s speech implies is that via the participation in EAP, the client is made aware of his or her “problem” through the facilitator’s expertise and guidance.

Libby establishes professional expertise as an EAP therapy-provider alternatively when I pursue the previous distinction she has made between “traditional” and non-traditional therapy (i.e., talk therapy and equine-assisted psychotherapy).

171 I: So, by doing that you have people um (4.0)...In MY opinion, I actually go
172 to a talk therapist. I do talk therapy, but I’m also out here s- and I’m also
173 certified. So for me to do EAP (2.0), it might not necessarily benefit me
174 because I know ex—I can sit there and psychoanalyze what’s going on.

Libby structures three claims in a successive order to establish authority with respect to the type of therapy she is practicing and providing. First, she states that because of her expertise as an EAP professional, it would not “work” on her. Then, she discloses that she is “recovered” from an eating disorder, and has practiced EAP on

herself. Yet, while she does self-facilitate EAP, she still participates in “traditional” therapy. Once more, Libby emphasizes that because of her expertise and knowledge of equine-assisted psychotherapy, it would not prove successful for her.

Elsewhere in her interview, Libby makes a point to audibly emphasize the credentials and qualifications of the therapy providers. This again, provides an example of Appaloosa staff utilizing “accounts of accreditation” which function to validate the “alternative” therapy practiced by their community.

When asked to explain what equine-assisted therapy is, Libby starts by saying that “I’ve just been certified” (line 45) which serves a dual function to one, position herself as a “expert,” and two, mitigate any “inaccuracy” about the subsequent claims she is about to make. For example, when asked about her use of the pronoun ‘we’ in her accounting of the E.A.S.E. sessions, she responds:

- 129 I: The licensed mental health counselor and the equine specialist.
130 R: Okay.
131 I: So, or the licensed certified addictions professional, the—whatever the
132 licensed, certified person is that yo[ur
133 R: [Mm-hm.
134 I: I’m on the mental health side.

By offering institutionalized examples of accreditation (i.e., certifications and licenses), Libby is attempting to legitimize and affirm her status as therapy-provider and the status of the “alternative” therapy practiced at the farm.

Similar accountability of “expertise” (lines 71-73) is done in an interview with Appaloosa staff member, Emily. Also similar to Libby’s accounting, is Emily’s construction of this type of therapy as “different” (lines 75-77) or “alternative.”

- 65 R: And you—I think you said the other day that when I asked you what you
66 wanted to do, um, once you graduated—if you were gonna continue

67 school or education, didn't you say that this was a—you were considering
68 this as a career option?
(...)
71 they wanna get better in. And I've always played sports my entire life so I
72 kinda always thought maybe I'd ya know, go towards physical therapy, n
73 like athletic rehab[ilitation
74 R: [Mm-hm.
75 I: or something like that. And um, again like I said, this type of WORLD, I
76 guess you can put it, um, I mean it's a whole different lifestyle, it's a
77 whole different, ya know, way of life I guess you could say.

By offering experience with a “traditional” form of therapy (lines 71-73, lines 212-213), Emily is positioning herself as qualified to speak on the benefits an oppositional therapy like equine therapy. This contrasting between “traditional” physical rehabilitation and the therapy practiced at Appaloosa Farm, is done later in the interview when Emily describes a participant's “progress” (lines 221-228) with equine therapy, and lack thereof with “conventional” therapy:

206 R: so what does it provide to you personally as an able-bodied person?
207 I: Um (1.5)...I mean, does that just mean riding in in general? Or this, this
208 facility, this place i[n
209 R: [Um...
210 I: specifically?
211 R: Maybe just riding in general for the first—
212 I: Um, well for me, with I mean, between college n, n softball n, n my
213 physical therapy myself, it's just (1) riding is very relaxing.
214 R: Mm-hm.
215 I: It's very (1.5) um, I mean, whether it's for ten minutes, or whether it's for
216 ya know, two hours.
217 R: Mm-hm.
218 I: It's just, just being in this environment—and that's one thing I can
219 definitely say for the disabled individuals, that it just, it kinda relaxes
220 your mind. N it just kinda helps ya calm down and filter out, ya know,
221 your thoughts n, n everything. N that's, ya know, kinda relates to the
222 disability people where they are more open to try new things or um,
223 where—like that John Parsons g[uy
224 R: [Mm.
225 I: his mom had said, um he's done—he's worked with a certain therapist for
226 four YEARS, and just coming out here for a few weeks, she can already
227 R: [Wow.
228 I: see a night and day difference just between the two types of therapies.

The theme of self reliability is a reoccurring discourse within the therapeutic setting. In lines 221-222, Emily describes the client's degree of "openness" as a prerequisite for the efficacy of therapeutic intervention. The responsibility of the client to be "open" to therapy is reinforced, serving to protect any negative evaluations of the success of the therapy provided. If the client neglected to demonstrate marked "progress" or development, in spite of participation in therapy, it can be defended that responsibility lies with the client for his or her inability or unwillingness to be "open." In other words, lack of openness on the client's behalf functions as an explanation for possible failure. This is just one more means by which the therapeutic enterprise is discursively protected from negative review.

The Self as Site of Incompetence

Discourses of development and progress are plentiful in the marketing literature for Appaloosa's E.A.S.E. program, or "Equine Assisted Self Exploration." Take for example, the line featured on the front page of the brochure which reads,

The horse's innate ability to sense that which is incongruent between the outward self and the inner self creates a powerful tool for self-exploration and adjustment.

Here the self is responsible for identifying his or her incompetence ("self-exploration") and correcting his or her deviance ("adjustment") through therapy. Identifying the self as the site of incompetence is problematic because such leaves the discourses which construct persons as "deviant" or "disabled" unquestioned.

In his 1977 chapter on *Docile Bodies*, Michel Foucault articulates that the emphasis on the correction of deviance stems from a concern for productivity and the

individual's contribution to society. With respect to Appaloosa's marketing literature, participating "constructively" (productively?) in relationships is a reification of this discourse.

Therapy may be interpreted as an institutional discourse which seeks to reform deviant (disabled) bodies. Horkheimer & Adorno (1972) concern themselves with the intersections of docile bodies and the Western conceptualization of "development." They assert that the notion of development is a normalizing discourse so ingrained that it is now fit to develop bodies. Development, as it is conceived of in Eurocentric societies, is positive. By extension, practices which develop bodies (i.e., therapy) are regarded as positive. The very premise of development though is that those nations, bodies, persons who are in the process of "developing" will never attain the status of "developed." Though the status of "developed" is unobtainable, the industries of "developing" persons such as those of therapy continue to thrive. By what means do the professionals of helping communities such as Appaloosa Farm establish and sustain their livelihood? I contend, as does Murray Edelman (1974), that such an accomplishment is achieved through the languaging of the practice:

Such a society can survive, and maintain its frustrating institutions, only as long as it is possible to manipulate the discontented into conformity and docility and to isolate or incarcerate those who refuse to be 'rehabilitated.' The helping professions are the most effective contemporary agents of social conformity and isolation. In playing this political role they undergird the entire political structure, yet are largely spared from self-criticism, from political criticism, and even from political observation through a special symbolic language. (p. 310).

Discourses of development are likewise presented in a list of objectives featured on page 3 of the pamphlet. The bulleted objective for program participants reads “Develop and implement effective skills to carry out normal responsibilities and participate constructively in relationships.” The individual with a disability is constructed here as ‘other’—as deviant—as incapable of exacting “normal” activities.

The Problem of Empowerment

Constructing individuals with disabilities as deviant and incapable is essential to the livelihood of the therapy industry as it legitimizes the need for “expert” therapeutic intervention. Empowerment, as it is addressed by informants in their talk, is the means by which this therapeutic intervention occurs. In discussions of empowerment, the focus remains on the individual with a disability, yet via the therapy-providers expertise, the individual can undergo development.

“Empowerment” perpetuates positivist conceptualizations of power as it implies that power is something to be had—something someone (the “expert” and therapy-provider) can give to another (the individual with a disability and therapy-receiver). To exemplify how empowerment works to keep the therapy-provider an authority, I will introduce an extract from an interview with the Appaloosa’s barn manager, Libby.

When asked to explain her use of the term “equine-assisted psychotherapy,”

Libby offers me the following hypothetical account:

- 47 I: So this is just the best example I can give of what it’s about. Um, he
48 comes in, and um, we know that he’s got anger management issues so why
49 don’t we give him a halter and a lead rope, and ask him to go (2.0) get his
50 favorite horse outta pasture, and bring it to us. And we stand, ya know, in
51 the pasture, n (1.0) we watch him go out n he might say, ‘Well I don’t
52 know what a halter is and a lead rope, wh- what, how do I use this?’
53 R: Mm-hm.
54 I: ‘Wh-well how do I put it on?’ And we say, ‘to the best of your ability.’ So

55 it's about empowering the person.
56 R: Mm-hm.
57 I: Um(1.0), it's about allowing them to learn how to process what's going
58 on. So all the sudden he comes up n he's irritated with us cuz we didn't
59 tell him how to do it, and he's mad
60 R: uh-huh
61 I: and he doesn't wanna be there, puts the halter on wrong and the horse
62 starts getting all fidgety and mad
63 R: Mm-hm
64 I: and runs away and starts bucking and all the horses get upset.

It is significant that Libby presents this account as the “best example” (line 47). She provides an account of a therapy session gone wrong—the client is frustrated at his inability to complete the task. Libby justifies the intervention of therapy personnel by describing how the client was incompetent or unable to complete the task assigned to him. By first constructing the client as “deviant,” she is able to justify and legitimize the need for therapeutic intervention and expertise. The assumptions presented in Libby’s talk are as follows: On his own, the client is incapable of executing the task. However, with the aid of the therapy-providers, and the empowerment they provide through their services, he will succeed.

The direct reported speech Libby uses exemplifies these assumptions in hyperbole; note how in lines 51-52 and 54, the client is portrayed as ignorant and quick to anger via the dramatization of the direct reported speech Libby uses. Libby’s subsequent use of directed reported speech which is intended to represent the words of the therapy-provider is by contrast, without stutter or question, and is succinct and collected (line 54). This directed reported speech of the hypothetical therapy-provider, “to the best of your ability,” suggests that the therapy-provider knows what ability is and can introduce such knowledge to the client.

Empowerment as it used by Libby, suggests a donor-deficit model (Airhehenbuwa, 1995; Dutta, 2008) of therapy wherein the therapy-provider imparts knowledge, expertise or sophistication to the subordinate receiver, i.e., the “disabled” program participant. When Libby describes her function in the therapy session as “allowing them to learn how to process what’s going on” (line 57), she affirms the role of therapy-provider as the one who gives, who facilitates or develops an ability.

The discourse of therapy in terms of individual “empowerment” also appears in the Appaloosa E.A.S.E. program marketing literature. Under the heading “Self Efficacy,” one of the listed benefits of E.A.S.E. includes, “Empowering an individual to take on challenges in other areas of their life” (p. 2). Further down on the same page, the initiative “Become empowered to expand your personal comfort zones” (p. 2) is detailed. Such accounts of empowerment do two things: one, they suppose that power is something to be given and received, and more importantly, that the individual receiving power is the program participant and person granting it is the therapy-provider. In other words, discursive representations of empowerment authorize the therapeutic intervention by constructing power as a commodity to be given and received. And if the intervention were not to work, the discourse of empowerment would be obsolete. Thus, in accounts of empowerment such as Libby’s, professionals must identify the individual as the source of incompetence to explicate and validate any instances in which the therapeutic intervention was unsuccessful. That way, the problem does not lie with the institution or its discourse, but rather, with the client. By continuing to discursively construct the client as the site of incompetence, Appaloosa professionals are ensuring that the efficacy of their therapeutic practices, in addition to their expertise, is exempt from interrogation.

Much like disability is constructed in social interaction, so too is the need for therapy. Therapy, and the discourses surrounding it, such as those of the development of bodies, and progress, are evaluated positively and are thus left largely unquestioned. As demonstrated in the program literature on the type of therapy practiced at this facility, discourses of empowerment and progress legitimize the need for the therapy-provider's expertise. Such discourses characterize power as a product which the therapy-provider possesses, and which, upon participation within the therapeutic setting, the therapy-receiver and client may eventually be granted. Empowerment becomes the prerequisite for the client's "progress." By constructing power as something to be owned and traded, professionals work to make their enterprise necessary. This is of particular importance as their therapy, which is traditionally regarded as "alternative" or 'other' within a dominant biomedical frame, is scrutinized for its effectiveness (i.e., in terms of clients' progress).

Karen Tracy (1997) asserts that the implications of research should be practical. My findings suggest very practical means for reevaluating the therapy industry. By inquiring about what the speaker or therapy-provider is trying to accomplish via the discourses he or she is employing, one effectively "disables" the taken-for-granted dominant discourses of dis/ability and therapy. In this paper, I demonstrate professionals' aims in constructing disability as an intrinsic identity characteristic. I demonstrate the strategic purposes of characterizing disability as such, including the primary purpose featured in this paper: safeguarding the therapy industry.

Chapter Four

Conclusion

The objective of my thesis was to interpret professionals' presentation of dis/ability in therapy through the analysis of talk and text as a means to interrogate largely unquestioned assumptions about the social order. As members of a culture, these professionals are tacitly versed in implicit assumptions regarding "the way things are," assumptions which guide their interactions within this community, which contribute to their sense of self as therapy-providers, and which influence the practices in which they participate daily.

My descriptions of these assumptions as "implicit" and "unquestioned" should not suggest however, that this bank of cultural knowledge with which each member is equipped is inaccessible. On the contrary, knowledge of dis/ability, therapy, psychology and matters of the mind, philanthropy, morality, and conceptions of power are all made manifest and done in interaction.

In my second chapter, "Organizing the Everyday," I demonstrated how understandings of dis/ability, therapy, psychology, philanthropy and morality were addressed by Appaloosa professionals in their talk, and in their organization's promotional literature. More importantly, I detailed their purposes for presenting and organizing these topics in the ways they did.

Disability was bifurcated into hierarchical subtypes of mental and physical by informants in order to (re)produce productive bodies—a claim which reinforces the

necessity of their therapeutic enterprise. Psychological notions of the mind as hidden from non-expert observation were also present within this hierarchal construction in that the presumed invisibility and limitlessness of mental disability posed a potential threat to the measurable efficacy of therapeutic intervention. Assumptions regarding philanthropy and morality were also implicit in professionals' categorical organization of community members and their activities. A morality of philanthropy was constructed in staff's presentation of the ideal volunteer, in the enumeration of "genuine" motives for volunteering, and in staff's self-positioning as "experts" qualified to make such assessments.

Conventional premises of psychology, including the representation of mind as a container hosting concealed information, were also featured in chapter three on "Accounting." Here, these assumptions about psychological workings served as the means by which Appaloosa professionals validated the need for therapy. By characterizing the client as "unaware" of an underlying problem, professionals secure the need for expert intervention in order to discover and treat the issue. Though Appaloosa staff account for departures between "traditional" therapies (such as psychotherapy and talk therapy) and those practiced within their community, they nonetheless employ the assumptions upon which "traditional" psychology is predicated for their own purposes.

Finally, the topic of power, though inescapably present in all my previous chapter discussions, is explicitly addressed by professionals' talk and their organization's literature in the form of "empowerment." The prefix 'em' of empowerment is instructive in that its meaning, "to put into," denotes a *transfer* of resources from one party to another. To empower then, is to put power into another, suggesting that this power was

not always already present in the recipient. This understanding of power proves useful to Appaloosa professionals in that they deploy this logic of power relations to legitimize their status as “experts,” and the status of their “alternative” therapy.

The dangers of presuming that power resides in structures and persons without consideration to the assumptions involved in such conclusions, is that such a practice makes renegotiating inequities difficult. The fact of the matter is that persons are incapable of being power-less because power is not something to be had, traded, or owned. In other words, power operates as capital not in the market exchange of it (i.e., in the therapeutic encounter), but in the languaging of it, which functions to sustain the interests of certain industries such as therapy.

Similar to power, disability is another immaterial resource which professionals seek to propertize through their talk. Therapy is a problem-determined enterprise, meaning that it needs to locate and identify a problem to treat in order to legitimize the services it provides. Disability is represented predominantly in a biomedical model as problem-centered. It is regarded as a biological construct inherent to the individual, as opposed to a social construct tied to cultural notions of normalcy. In this way, disability supplies therapy with the problem it needs to sustain itself as a helping industry, and as a result, professionals are interested in the right to represent disability. As shown in chapter three on “Accounting,” Appaloosa professionals simultaneously work to construct themselves as experts worthy of the ownership of these rights and to discredit competitors (i.e., “traditional” therapies such as talk therapy).

Questioning assumptions about power, and the social phenomena I’ve mentioned above, is essential to altering social inequities. To change inequities one must first, trace

and interrogate the assumptions upon which they are founded. Once the implications of these assumptions are explicitly delineated, one can take action to renegotiate their entailments in everyday life (through reappropriation, for instance). Essentially, the task which I have hoped to accomplish here, and which I encourage others to adopt in research and in praxis, is to make the invisible visible.

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Appendices

Appendix A: List of Informant Interviews

Interview with Emily, an Appaloosa staff member. Conducted on March 9, 2009.
Duration: 21 minutes.

Interview with Robyn and Maria, Appaloosa volunteers. A joint interview conducted on April 21, 2009. Duration: 29 minutes.

Interview with Betty Phillips, Appaloosa founder and president. Conducted on February 9, 2009. Duration: 43 minutes.

Interview with Rob Taylor, Appaloosa participant, and member of the organization's board of directors. Conducted on March 19, 2009. Duration: 37 minutes.

Interview with Libby, Appaloosa staff member. Conducted on October 28, 2009.
Duration: 46 minutes.