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FACULTY OF GRADUATE AND
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Constructions of Health and Fitness Among Adolescents with Mobility Impairments

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UN/HEALTHY, UN/FIT, DIS/ABLED:
CONSTRUCTIONS OF HEALTH AND FITNESS
AMONG ADOLESCENTS WITH MOBILITY IMPAIRMENTS

by

MORGAN A. SEELEY
B.Kin, McMaster University, 2002

THESIS

Submitted to the Faculty of Graduate and Postdoctoral Studies
in partial fulfillment of the requirements
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Morgan

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ABSTRACT

The present study explores the discursive constructions of health, fitness and disability among eight 14-17 year old youth with variety of mobility impairments living in the Ottawa area. Located within a framework informed by feminist poststructuralist and disability theories, the study is based on a content analysis of guided conversations and individual journals in which participants were involved. Results indicate that participants discursively construct health and fitness in corporeal terms such as being active, eating right, and having a good body. Within their constructions, participants both resist and rearticulate dominant health, fitness and disability discourses. Results also highlight a variety of discursive strategies used by participants to both defy oppressive stereotypes related to gender and disability and to construct themselves as healthy and fit individuals. Insights gained from this study begin to fill an important gap in North American literature on the experiences of youth with disabilities. Such insights may be used to inform the development of programs aimed at improving the health, fitness and well-being of Canadian adolescents.

CHAPTER I

INTRODUCTION

Disabled children live within a society whose cultural values and sociocultural relations and physical environment operate so as to create a stereotypical image of what a disabled child should be.... Structure, culture and agency are fused into every social setting. This fusion is not fixed in either time, place or person; it is fluid and open to change and, as such, so are disabled children (Davis & Watson, 2002, p. 170).

“[O]besity epidemic” (Wright, MacDonald & Groom, 2003, p. 17), “significant decline in physical activity” (Strauss, Rodzilsky, Burack & Colin, 2001, p. 900), “increase in obese and superobese children” (Kuntzleman, 1993, p. 523); these statements reflect widespread concerns over the health and fitness of North American children and adolescents. Dating back to the 1980s, these concerns have led to the development of numerous research studies and health promotion programs. However, despite the implementation of such programs, research suggests that the health of young Canadians is less than encouraging. For example, while evidence suggests that Canadian youth are knowledgeable about health, this knowledge does not necessarily translate into practice (LeGrand, 2002). Research also suggests that youth of marginalized socio-cultural groups tend to fair less well in terms of health and fitness practices. Of particular concern are the disproportionately high rates of idleness in adolescents with disabilities and/or chronic illness (Ireys, Salkever, Kolodner & Bijur, 1996), and the over-

representation of youth with disabilities exhibiting poor body image, depression, and high anxiety over their health status (Boice, 1998).

The initiation of projects aimed at youth to reduce teen suicide, teen pregnancy, drug and alcohol abuse, sexually transmitted diseases, and obesity are well warranted if physical, social, and psychological development during adolescence lays the ground work for life-long health and well-being (Vingilis, Wade & Seeley, 2002). School physical and health education programs, the media, government initiatives, and independent health service providers have identified this phenomenon and, appealing to an ideology born out of the fitness and health “boom” of the early 1980s (McElroy, 2002), bombarded Canadian adolescents with messages dictating the importance of taking health into their own hands. Wrapped up in discourses of economic rationalism, public and private health promoters have capitalized on this ideology, developing and perpetuating “health promotion” and “health prevention” strategies to produce citizens who are not a burden to the national economic and health care systems (Howell & Ingham, 2001).

While health promotion and prevention programs seemingly aim to increase the health and well-being of North American adolescents, considerations about the possible negative consequences of dominant health and fitness discourses remain marginal. Fortunately, researchers in the areas of the sociology of health and physical activity and physical education have begun to develop a body of literature highlighting their concerns over the messages brought about by current health ideology. Much of this literature is based on Crawford’s (1980) twin concepts of “healthism” and “individualism”. According to Crawford (1980), the concept of “healthism” refers to the set of discourses

that construct health as an unproblematic good. “Individualism” refers to a set of ideas and practices that assume individuals will always act in their own self-interest. The interplay between these discourses perpetuates the notion that achieving health is the sole responsibility of the individual.

In identifying and deconstructing dominant health and fitness discourses articulated through a variety of sources such as physical education classes, fitness videos, and government initiatives, research suggests that contemporary culture has centered on the body, and specifically body shape, size, weight and ability as measures well-being, health, and morality (e.g., Kirk & Colquhoun, 1989; MacNeill, 2000; White, Young & Gillett, 1995). Notably, popular images of the “healthy”, “moral”, and “ideal” body contrast strikingly with cultural images of youth with disabilities.

In North America, health care providers traditionally interested in the prevention of disability and chronic illness are recognizing a need and potential market for “secondary” health services directed at people with disabilities (Rimmer, 1999). However, when targeting the cardiovascular endurance, strength, and flexibility of people with disabilities, the term “health promotion” tends to be replaced by the term “rehabilitation” (Rimmer, 1999). This rehabilitation discourse found in health promotion literature and programs has been critiqued by disability activists who suggest that under this model, people with disabilities are seen as being in constant need of care by experts (Bricher, 2000). In addition, rehabilitation and medical discourses of disability intersect with dominant discourses of health and fitness in ways that promote physical activity as a means to manipulate the disabled body into some degree of “normalcy” (Barnes, Mercer & Shakespeare, 1999).

Qualitative studies aimed at exploring the experiences of people with physical disabilities from a socio-cultural context have begun to appear in North America (e.g., DePauw, 2000; Duncan, 2001; Tighe, 2001). Following the “social model” of disability, such studies suggest that in addition to the physical benefits of regular physical activity, adults, adolescents, and specifically women with disabilities, may practice physical activity and sport in order to resist oppressive stereotypes about their bodies, develop social networks, and gain a sense of empowerment (Ashton-Shaeffer, Gibson, Holt & Willming, 2001; Guthrie & Castelnovo, 2001; Taub, Blinde & Greer, 1999). While these studies represent an important step in exploring the health, physical activity and sporting experiences of people with disabilities, methodologically and theoretically, they tend to overlook current developments in the field of disability studies.

To date, little qualitative research has examined the experiences of Canadian youth with disabilities. Research that has focused on this group tends to do so from a biomedical standpoint. Such research has depicted adolescents with disabilities as passive, vulnerable and dependent (Davis & Watson, 2002), objects to be “fixed”, or reminders of the importance of developing and perpetuating health and risk prevention programs (Darrah, Magil-Evans & Adkins, 2002). By overlooking the personal experiences of youth with disabilities, research has been unable to uncover what health and fitness mean to youth with disabilities, or of what importance health and fitness practices are to their lives and identities.

Objectives

The general aim of this study is to gain a better understanding of how Canadian youth with physical disabilities discursively construct health and fitness. This project

focuses specifically on Canadian youth 14 to 17 years old with various mobility impairments living in the Ottawa region at the time of the study. The main objectives of the study are: (a) to understand how young people with mobility impairments construct health and fitness; (b) to understand how dominant and alternative discourses of health, fitness and disability are taken-up by these youth; (c) to uncover how their constructions of disability and the body interact with their understandings of health and fitness; (d) to identify the sources of institutional and cultural discourses of health and fitness from which they draw their ideas and construct their subjectivities; and (e) to understand the ways in which young people's ideas about health and fitness are gendered. This study has the secondary aim of integrating feminist poststructuralist and disability studies scholarship in order to develop methodologies and theory that better uncover and appreciate the ways in which youth with a mobility impairment construct subjectivity and negotiate identity.

Significance of the Study

Currently, programs and initiatives aimed at improving the health and well-being of Canadian adolescents tend to be based on adult and able-bodied understandings of health and fitness. As a result, these programs may not coincide with the beliefs and needs of the Canadian adolescent population and, in particular, the disabled adolescent population. For instance, although physical education and community programs in Canada and internationally aim to increase the fitness levels of young people, the fitness activities corresponding to these initiatives are often viewed negatively by youth (Sleap & Wormald, 2001). In addition, while Canadian studies have indicated that adolescents are more knowledgeable about health and fitness, this knowledge is not transferring into

behaviour (LeGrand, 2002). By uncovering how youth themselves discursively construct health and fitness, and in examining how they read contemporary health and fitness discourses, we begin to fill an important gap in the Canadian literature on health and fitness.

Examining the ways in which health and fitness discourses intersect with discourses of disability and the disabled body furthers theoretical understandings of healthism, and adds to the limited body of empirical work on this subject. Similarly, understanding the relationship between health and fitness ideology and dominant discourses of disability and impairment adds to discussions on disability discourse currently emerging from the field of disability studies.

The knowledge acquired throughout the process of this study leads to a better understanding of the specific health and fitness beliefs, needs, and concerns of adolescents with physical disabilities. This information has the potential to assist physical educators, health professionals, and community leaders in changing or developing interventions aimed at improving the health and well being of adolescents with physical disabilities in ways that do not discourage involvement in physical activity. This information may also be used to inform the development of new health-related policy initiatives and educational programs that are better attuned to the concerns and realities of this specific population.

Empirical research focusing on youth with disabilities has been heavily critiqued for marginalizing their personal experiences (for critique, see Davis & Watson, 2002; Garth & Aroni, 2003; Priestley, 1998). In particular, research on youth and children with disabilities has relied heavily on parents and caregivers to express the experiences of

these youth rather than focusing on the youth themselves (Garth & Aroni, 2003). In contrast, this study privileges the voices, experiences and understandings of youth with disabilities themselves. As such, it is a positive and much needed contribution to empirical sociological work on youth and disability.

Finally, the theoretical and methodological considerations and practices developed over the course of this study have much to offer current scholarship in the areas of health and sport sociology, women's studies, and disability studies. The multidisciplinary nature of this project illuminates various theoretical and methodological insights from a variety of areas. Merging and reconstructing theories and methodologies from feminist and disability scholarship lead to new insights concerning the development of less oppressive research designs and of theorizing dis/ability. This project offers future researchers alternative ways of "doing" disability.

Placing Myself in the Research

Research on disability by non-disabled scholars has been a topic of great interest and critique within the area of disability studies. Much of this research has resulted from the fact that historically, people with disabilities have been oppressed by researchers. Their unique knowledge has been violated as non-disabled researchers "parasitise [sic] disabled people's experience and develop careers on the back of disabled people's lives" (Shakespeare, 1996, p. 118). As a non-disabled researcher, it was important for me to state my motivations toward disability scholarship and to be self-reflexive at all stages of the project.

I became interested in disability scholarship and activism as a result of several volunteer experiences that began when I was in the third year of my undergraduate

degree. Prior to this time, I had not had much exposure to people with physical disabilities. I recall constructing people with disabilities as unfortunate, and I considered their lives to be not quite as full or complete as my own. Overwhelmingly, I feared disability. I was worried that I would stare if I came across a person using a wheelchair, or worse, pretend they did not exist. Rather than attempting to learn about the experiences of people with disabilities, I stayed away from writing papers about disability or taking classes that focused on disability. I did not want to be reminded of the instability of the human body. However, this changed when I was required to fulfill a number of volunteer hours as part of a class credit. This volunteer work consisted of acting as an exercise trainer for adults with spinal cord injuries as part of a study being done at the University. It was here that I first met Corey (she asked me to use her real name). Corey was (and is) a few years younger than me and uses a motorized wheelchair. We spent a lot of time together during her workouts. I assisted her with the workout equipment and we shared stories and gossiped about our lives. Corey's physical strength surprised me and led me to rethink my ideas about physical disability. To be honest, neither of us really cared too much about the working out part, although we did like to challenge some of the young guys at the center to lifting competitions just to see them get angry when Corey beat them! What I really liked about the center was just getting to spend time with Corey. She is quite a tough and sarcastic woman, and I think she valued some of the same attributes in me.

I did not feel sorry for Corey because she has a disability. What made me upset was not the impairment, but environmental and structural barriers, like the fact that I could not invite her over to my house because of the stairs and ledges at each entrance. I think this

is where my interest in disability studies and disability activism commenced. Corey and I would talk about how annoying and dangerous the narrow and steep ramp to the gym was, especially when it was covered in ice in the winter. She told me stories about the inaccessibility of her school and how if there was ever a fire alarm at her school and the elevator was shut down, she would have to wait for a caretaker to come and carry her down the stairs on his back!

The more I learned about the disability movement, the more I realized how people with disabilities are silenced in Canadian society. Images of people with disabilities are rare and, when they are present, they are consistently negative or inaccurate. As a feminist, I have noticed the absence of experiences and voices of people with disabilities from the feminist literature. As a “health scientist” seeing so much research focusing on “curing” or “fixing” people with disabilities infuriates me. I also recognized that as a researcher, I have an opportunity to give voice to the insightful and complex experiences of other young people like Corey.

When I came to the University of Ottawa, I was presented with the opportunity work on a project on the discursive constructions of health and fitness among Canadian youth. This project provided me with the opportunity to focus on what I considered to be an incredibly marginalized group of youth: those with disabilities. However, as a temporarily able-bodied young woman, I was concerned with producing research that objectifies, alienates, or violates the experiences of the youth in my study. As such, it was important for me to gain a better understanding of the lives and concerns of the population I would be interviewing.

For me, this process involved volunteering with a number of organizations whose goals are in part to provide recreation and physical activity opportunities to youth and children with various disabilities. Through these experiences, I developed sensitivity to the diversity and complexity of the realities and identities of these youth. Participating with a variety of youth with disabilities in various (and, unfortunately, marginalized) forms of physical activity and recreation allowed me access to some of the concerns, interests and experiences of this community of youth. Through observation and active interaction, I found myself in a better position to understand the context within which these youth construct their understandings of health, fitness and disability. Subsequently, as I formed relationships with various youth, I developed a personal allegiance to the advancement of opportunities for youth with disabilities to participate in physical activity and recreation, and a commitment to supporting the communities that made this research possible.

CHAPTER II

REVIEW OF LITERATURE

‘Well, at least you still have your health.’ A person’s health is seen as a priceless possession... [N]o monetary value can be put on health and, consequently, health is often held as the trump card.... Good health is the ultimate commodity (Tighe, 2001, p. 511).

As an adolescent, the health and physical education programs in which I participated focused on making healthy individual lifestyle choices. They informed me of the dangers of smoking, unprotected sex, and consuming high cholesterol foods. At the same time, popular media invaded my home with messages from celebrities and “health professionals” emphasizing the foods I should eat to prevent cancer and heart disease, and dictating the multiple ways in which I could develop and maintain a “fit,” “beautiful” and “healthy” body. When I think back on how I reacted to these messages, I do not recall being overly concerned with my physical, psychological, or emotional health. I did not consider my emotional or psychological well-being a measure of my health status and as an athlete, I believed my physical fitness was much better than the average young person. As a student, I believed the information I would gain from health education classes, books, and magazines would always lead me to making “good” lifestyle choices.

When I first started working with people with mobility impairments, I became acutely aware of the narrowness of my constructions of health, fitness and the “healthy” body. To me, the impaired or “abnormal” body could never achieve the status of “healthy”. In fact, I equated “unhealthiness” with “disability”. My lack of interaction

with youth with disabilities led me to the false assumption that participation in sport and physical activity was not something most people with physical disabilities did or were interested in. Fortunately for me, the ways I understand disability in relation to health and fitness have changed dramatically. As my own understandings of disability, the “ideal” body, and “healthiness” change and evolve, I have become increasingly interested in how youth with physical disabilities discursively construct notions of health and fitness and how these constructions inform their understandings of disability and impairment.

The present chapter explores current literature related to youth with physical disabilities and to youth’s constructions of health and fitness. Currently, no research has examined how youth with disabilities discursively construct health and fitness. However, a limited number of studies have explored issues related to this topic. This chapter is divided into four main sections. In the first section, I review qualitative literature focusing on the experiences of youth with disabilities in western society. In the second section, I examine literature on the health status of adolescents with physical disabilities as well as studies on youth with physical disabilities coming from the areas of the sociology of health and physical activity. In the third section, I focus on research examining the presence and nature of health and fitness discourses perpetuated by a variety of media and social institutions. Finally, the last section gives an overview of recent research concerning how youth and people with disabilities discursively construct health, fitness and physical activity.

Youth with Physical Disabilities

Adolescence is characterized as a time of great change and difficulty for most individuals (Butler, 1998). It has also been described as a period of time where lifestyle

patterns of behaviour are forged (Vingilis, Wade & Seeley, 2002). A recognition of the complexity and changing nature of adolescence has led to a growing body of work examining youth cultures (e.g. Butler, 1998; Skelton & Valentine, 1998), and documenting the unique social and cultural experiences of individual adolescents and youth groups (e.g. Wyn & White, 1997; Middleton, 1999; Messner, Gatz, & Ball, 2002). Notably, Sadowski has examined how students' successes and difficulties during adolescence revolve around the ways in which they negotiate questions of identity such as 'Who am I?' . . . 'What things are important to me?' . . . [and] 'How do other people perceive me?' (2003, p. 2). Wyn and White (1997) have focused on adolescence as a social process. They argue for an acknowledgement of the diversity of adolescent experiences and for the deconstruction of discourses that universalize the lived experiences of youth.

Youth with disabilities make up a significant percent of the adolescent population in North America. It is estimated that 3.6 million youth ages 15 to 24 are living in the United States (McNeil, 1997). In Canada, there are an estimated 84,350 children and youth ages 10 to 14 years old with a disability, and an additional 151,030 adolescents ages 15 to 24 with disabilities (Cossette & Duclos, 2002). Despite the popularity of research concerning youth and the significant number of youth with disabilities in North America, the experiences, voices, and representations of this group are largely absent from both academic and popular texts (Butler, 1998). Furthermore, popular representations and dominant discourses of youth with disabilities tend to be negative. These youth are often portrayed as passive charity cases (Davis & Watson, 2002), "super cripples", or in the case of fictional texts, evil "monsters" (Butler, 1998, p. 83).

Fortunately, the growing field of disability studies has made room for the voices of adolescents with disabilities. Scholars within this field are developing a body of knowledge that focuses on examining and deconstructing stereotypical images and discourses of youth with disabilities and circulating alternative constructions of disability and impairment.

Middleton (1999) suggests that historically, research examining the difficulties youth with disabilities experience during adolescence are based on an individual model of disability. Specifically, most studies focus on biological impairment to explain why youth experience disadvantage (e.g., Anderson & Clarke, 1982). Youth are portrayed as unfortunate, and disability is represented as a burden. In addition, these studies have overlooked the perspectives of youth with a disability (Davis & Watson, 2001); rarely including the words of youth they have studied. Instead, most studies tend to focus on the perspectives of parents, caregivers, teachers and therapists (Garth & Aroni, 2003). Priestly suggests that by excluding the perspectives of youth, the ways in which youth with disabilities “function as social actors, negotiating complex identities within a disabling environment” is concealed (1993, p. 93). Finally, Davis and Watson (2002) argue that the tendency of most studies to emphasize the care and services youth with disabilities receive perpetuates a discourse of youth with disabilities as dependent, passive, and a burden to the welfare state.

The formation of the UN Convention on the Rights of the Child stating that children and youth have the right to voice their opinions about issues that affect them and have their concerns heard (Garth & Aroni, 2003), concurrently with the development of the disability rights movement, have led recent studies to privilege the voices of youth

and children with disabilities, and to focus on alternative discourses of disability and impairment. For instance, Middleton (1999) interviewed university students with physical and sensory disabilities about their childhood experiences. Through the voices of her participants, Middleton examined how experiences of childhood were complicated by the negative attitudes and behaviours that their family members, other children, care professionals and other adults held towards disability. Middleton showed how non-disabled youth undermine the achievements of students with disabilities by suggesting that their successes are a result of teachers feeling sorry for them.

Middleton's study (1999) is exceptional in identifying sources of dominant discourses of disability. Her research explores how such discourses complicate the experiences of adolescents and how youth with disabilities are aware of the ways in which they are being controlled and oppressed. In addition, Middleton's is one of the few studies on youth with disabilities to document the experiences of youth with disabilities in the words of the participants (although in this case it was retrospectively). While Middleton's study is a step in the right direction, critiques of this study indicate suggest that including the voices of youth with disabilities is not enough to ensure less-oppressive research designs (Davis & Watson, 2002). A central critique is that researchers have tended to characterize youth with disabilities as a homogeneous group by presenting understandings and experiences of disability as relatively universal.

Fortunately, more recent studies on youth with disabilities emphasize the diversity of experiences of disability and the heterogeneous ways in which youth with disabilities deal with discrimination and oppression (e.g., Baron, 1997; Davis & Watson, 2001; Davis & Watson, 2002; Garth & Aroni, 2003; Priestley, 1999; Wehmeyer, 2003). For

example, a study by Davis and Watson (2002) suggested that youth with disabilities actively resist an imposed disability identity. For example, some youth used body language such as flinching in reaction to patronizing actions by teachers. Others used verbal resistance such as telling off a teacher or interrupting the class. Still others used physical resistance such as hitting to resist classmates who were oppressing them. Wehmeyer (2003) notes that young women with disabilities and students with disabilities who come from ethnic and racial minority groups negotiate stereotypes, biases and negative attitudes that other students with disabilities do not experience. He argues that expectations of academic achievement are affected by stereotypes related to disability *and* race. Stereotypes of disability and race may play a role in the disproportionately high drop out rate for youth of colour with disabilities who start high school.

Exploring the relationship between discourses of gender and disability is of central concern to many feminist disability scholars (e.g., Barron, 1997; Butler, 1998; Ruosso, 1988). In one of the earliest sociological studies exploring the experiences of youth with disabilities, Ruosso (1988) examined the interaction between disability and heterosexual activity in a group of women with physical disabilities. She suggests that women who are disabled before adolescence tended to perceive themselves as less socially successful compared to their non-disabled peers, and are sexually active at a later age than those women who acquired their disability after adolescence. Participants in this study attributed differing experiences to attitudinal barriers such as prejudicial friends or parents not viewing them as sexual beings. Waxman (1996) argues that an examination of how gender intersects with disability is essential for women with disabilities. The intersection of stereotypes that equate femininity with dependence and passivity, and

stereotypes that equate disability with the same have resulted in very little research examining the sexual and reproductive well being and experiences of women with disabilities.

Barron (1997) is one of few scholars who has examined the experiences of young women with physical disabilities. Using data collected through interviews with six physically disabled young women, she argues that many of the stereotypes young women with disabilities encounter are closely linked to traditional gender roles. For example, interviews with participants revealed that many of the women in this study do not think about their physical appearance in positive terms. The pressure placed on all women to attain a particular bodily ideal in western society informed ideas about the physically disabled body as in need of repair or as not “whole” (p. 230). Such discourses inform young women’s perceptions of their own physical attractiveness. Studies focusing on disability and gender are in great demand. As indicated by the studies described above, experiences of disability are extremely diverse and disability is not always the most important aspect identity or subjectivity. As such, future research on youth with disabilities is needed to better understand how discourses and constructions of disability are complicated by discourses of gender, race, sexuality, and other relations of difference.

Discourses and Images of Youth with Physical Disabilities

A common theme is found in the majority of literature concerning the experiences of youth with disabilities. Each of these studies deal in some way with images of youth with disabilities and how dominant discourses surrounding disability both inform identity and are resisted by youth. Wehmeyer argues:

[The ways in which] disability is understood and viewed by peers and others in society is a key component of the construction of identity for young people with disabilities, and the fact that disability is associated with stigma also greatly impacts the construction of self for these youth. (2003, p. 128)

Bryan suggests that while most North Americans may believe that we have progressed beyond negative attitudes of people with disabilities, “crude negative attitudes towards persons with disabilities once deeply rooted in the superstitions and mythologies of the ancestors of modern people have evolved into present-day sophisticated bigotry” (2002, p. 4). Similarly, Wehmeyer states that discourses associating disability with charity and dependence are visible in everyday interactions. “People with visual impairments are spoken to in loud voices with clearly (and slowly) articulated measure; adults with cerebral palsy are patted on the head by well-meaning strangers” (2003, p. 129). In the present section, I explore many of the dominant discourses and images of youth with disabilities, revealing the ways in which such images are narrow and oppressive.

Popular representations of youth with disabilities have been examined in much of current research on youth with disabilities. It has been argued that discourses of normalization and difference as well as dependency and charity, have seeped into interactions between youth with disabilities, teachers, other adults, and non-disabled peers. For example, Butler assembled a list of stereotypes and dominant discourses regarding youth with disabilities based on data gathered from interviews with youth with sensory and physical impairments. Results indicated that youth with disabilities are problematically represented as unintelligent, unhealthy, frail, asexual, dependent, ugly, a burden to society, and/or “bitter and twisted” (1998, p. 93).

More recently, Davis and Watson (2001) found that children with disabilities are oppressed by ideas of “difference” and “normality” in mainstream schools in the United Kingdom. It is argued that teacher’s were regularly reminding youth with disabilities of their difference; a process the authors describe as “labeling”. On the other hand, youth were being forced (sometimes physically) to “correct” or fit into “normal” ways of moving and behaving. This process of normalization erased any space for the exploration of positive aspects of difference.

A study by Priestley (1999) examined how discourses encountered by high school students with disabilities contribute to constructions of identity and constructions of disability as a social concept. Specifically, it was found that youth were being constructed as different in being excused from certain school activities and being separated from other classmates when a “special-needs” assistant would come to assist them. However, Priestley suggests that youth with disabilities not only resist discourses of difference, but also temporarily adopt a “disabled” identity when it is advantageous for them to do so. For example, high school youth with physical disabilities would “use” their difference to get out of class or avoid being reprimanded by teachers.

The studies discussed above clearly demonstrate that youth with disabilities are surrounded by problematic images and discourses of disability in their everyday lives. What is also apparent is that youth with disabilities differentially interact with, take-up and resist problematic discourses and images of disability. The ways in which these youth resist dominant images and discourses, perform disability and negotiate disability discourses is indicative of the diversity of experiences of disability during adolescence.

From these studies, it becomes apparent that further research on the experiences of youth with disabilities is much needed.

Health and Physical Activity Research on Youth with Physical Disabilities

Bricher (2000) argues that historically, research by health professionals regarding disability has ignored the social aspects of disability attending primarily to the individual and the impairment. As Darrah, Magil-Evans and Adkins suggest, “[t]raditionally, policy and research issues concerning persons with disabilities were primarily identified by biomedical concerns.” (2002, p. 542) Based on an individual or medical model of disability, such literature focuses on curing and preventing impairment and tends to treat people with disabilities as passive research participants. My own examination of more recent studies on the health status and physical activity experiences of adolescents with physical impairments revealed that in the area of health, disability remains a “problem” of the individual. However, with developments in the field of disability studies, and accompanying attitudinal changes at the societal level, recent research efforts in the areas of physical activity and health are moving away from the limitations and oppressive nature of earlier research on youth with disabilities. The purpose of this section is to give an overview of health and physical activity research on youth with physical disabilities in order to understand where gaps lie within this area of scholarship.

According to the 2001 Canadian Participation and Activity Limitation Survey (PALS), mobility problems are the most frequently reported disability in youth and adults fifteen years of age and older (Statistics Canada, 2002). In 2002, it was reported that “nearly 2.5 million or 10.5% of Canadians [have] difficulty walking, climbing stairs, carrying an object for a short distance, standing in line for 20 minutes or moving about

from one room to another.” (Statistics Canada, 2002, p.15) In addition, it is well known among rehabilitation and health care “professionals” that adolescents with physical disabilities are at high risk of developing secondary disabilities such as cardiovascular and respiratory disorders later in life (Hodges, 1986; Marge, 1988). Despite the research, few studies have focused on the health of people (and specifically youth) with physical disabilities. Of the available research, studies on the health of youth with physical disabilities are primarily quantitative and descriptive studies. As a whole, these studies indicate a lower health status in youth with disabilities in comparison to their able-bodied peers.

Boice (1998) has constructed a review of literature on the health of adolescents with chronic illnesses. Her research indicates that a growing mortality rate in youth with chronic illnesses and disabilities has led to an increased interest in the well-being of these youth as they reach young adulthood. Boice addresses the social, psychological, biological and cultural issues and concerns surrounding the health of youth with chronic illness; however, it is apparent that psychological and cognitive studies have dominated health research on youth with disabilities. For example, Wolman, Resnick, Harris, & Blum (1994) examined the emotional well-being of adolescents with chronic disabilities. Using a sample of over 1600 American youth with disabilities in grades seven to twelve, the research indicated that students with chronic conditions have a significantly lower emotional well-being than students without chronic conditions. In addition, participants with disabilities were more worried about dying, and males with disabilities expressed higher concerns over interpersonal relationships with peers. Interestingly, having a chronic condition was only the fourth most important variable in predicting emotional

health. For adolescents with chronic conditions, body image, family relationships and worries about school and future employment are stronger indicators of emotional well-being.

In a similar study, Stevens, Steele, Jutai, Kalnins, Bortolussi and Biggar (1996) examined psychosocial issues related to the health of adolescents with physical disabilities. Researchers administered the *Health Behaviours in School-Aged Children* survey (HBSC) to 101 Canadian youth with physical disabilities aged 11 to 16. This survey has been designed to assess psychosocial health via measures of self-esteem, body image, social integration, attitudes to school, and strength of family relationships. When compared to a national sample of adolescents, researchers found that youth with physical disabilities had equally positive attitudes to school and had a similar number of friends as adolescents in the national sample. However, results also indicate that youth with physical disabilities have greater difficulty communicating with friends or spending time with them outside of the school setting.

In contrast to previous studies, Stevens et al. (1996) found that youth with physical disabilities had similar levels of self-esteem and body image when compared to a national sample. This discrepancy may be accounted for by the limits of quantitative research. Specifically, the authors suggest that measures of self-esteem may not be sensitive enough to measure differences between groups of youth. The use of semi-structured interviews may have been more useful in determining differences between disabled youth and non-disabled youth. Similarly, differences between friendship experiences may be examined more fully by using a range of qualitative measures. For example, future

qualitative research efforts could be used to examine the barriers that make it difficult for youth with disabilities to develop friendships outside of the school setting.

Issues related to the physical health of youth with physical disabilities and chronic illnesses are prevalent in current literature. Specifically, studies on the health of people with physical disabilities tend to focus on the susceptibility of this population to secondary health conditions (Rimmer, 1999). For example, Rimmer (1999) found that people with spina bifida and cerebral palsy are affected by osteoporosis, osteoarthritis, decreased strength and endurance, decreased flexibility and fitness, weight problems, depression, and other secondary health concerns. However, further research is required to better understand the secondary health conditions specific to youth, and how these concerns impact youths' constructions of health and fitness.

Finally, research on the sexual health of youth with physical disabilities are in great need considering the historic infantilization and asexualization of people and specifically women with disabilities (see Waxman, 1996). Boice argues that issues around sex and sexuality "may produce anxiety [in youth with physical disabilities] yet are often ignored or denied by the adolescent's family. Most adolescents want to be given specific information about their sexual options and reproductive potential" (1998, p. 929). A study examining the sexual and reproductive health of youth with spina bifida reinforces this argument. Specifically, Sawyer and Roberts (1999) used structured interviews to identify the sexual and reproductive attitudes and knowledge of 51 youth and young adults with spina bifida. The interviews revealed that while youth with spina bifida receive a substantial amount of general sex education, they lacked sexual and reproductive information specific to their disability. Similarly, Stevens et al. (1996) reported that the

majority of adolescents with physical disabilities in their study were not receiving information on topics such as birth control, STDs, sexual abuse and parenthood.

Sawyer and Roberts (1999) suggest that as a group, youth with disabilities have a high proportion of unplanned pregnancies and a high rate of sexual abuse. Youth in this study had a lot of questions concerning their sexual and reproductive health, and expressed a desire to talk to their doctors about such issues, but only if doctors were willing to initiate such conversations. Taken together, these studies indicate a need for additional research on the socio-cultural barriers to sexuality and sexual health related to youth with physical disabilities. In addition, research on youth with physical disabilities should focus on how an absence of discourses related to sexual and reproductive health impact health identities of youth.

As mentioned previously, youth with disabilities are at an increased risk of developing secondary physical health conditions that are often associated with lifestyle (e.g., cardiovascular and respiratory disorders) (Stevens et al., 1996). In addition, previous studies indicate that youth with disabilities tend to have lower emotional well-being (Wolman et al., 1994), and lack knowledge concerning their sexual and reproductive health (Sawyer & Roberts, 1999). Despite these concerns, research in the area of health promotion has not shown much interest in developing health promotion programs for youth with disabilities.

Rimmer (1999) posits that studies on health promotion for people with disabilities are almost completely absent from health literature. As traditional and dominant health discourses define health as the absence of disease, “the individual [with a disability] was not considered a good candidate for a health promotion program because the aim of

health promotion was not to take care of the 'sick' and 'disabled', but rather to prevent disease and disability in the 'healthy' (Rimmer, 1999, p. 497). However, as mortality rates in people with disabilities continue to increase, secondary health conditions are becoming more of a concern to health professionals. A recent focus on cost reduction has led rehabilitation centers and hospitals to realize that health promotion is essential for people with disabilities, as illness can "compromise their functional mobility" and lead to their greater dependency on others and on the health care system (Rimmer, 1999, p. 497).

Rimmer (1994; 1999) has developed his own model of health promotion for people with disabilities. This model focuses not on creating networks between health care professionals and fitness professionals, but, on extending these services into the community where they can be accessed by people with disabilities. Rimmer argues that health and fitness professionals need to become more educated and aware of issues surrounding disability and health promotion. He suggests that this model of health promotion is attentive to societal barriers to improving the health of people with disabilities, such as inaccessible facilities and the high rates of poverty among this population. However, current health promotion research aimed at people with disabilities has not yet been critically reflected upon. Additional research could examine the ways such health promotion programs may promote problematic discourses concerning the individual responsibility of people with disabilities to control and maintain their own health.

Most health promotion guides (e.g., Rimmer, 1994; 1999; Rimmer & Hedman, 1998) aimed at people with disabilities have focus on adult understandings and experiences of health and physical activity. For example, Rimmer (1999) emphasizes the

importance of community fitness centers that are accessible and adapted to meet the needs of people with disabilities. However, researchers have not yet examined if youth with disabilities are interested, comfortable or have easy access to such facilities.

Qualitative studies on the health and physical activity experiences of youth with disabilities are beginning to emerge. These studies focus on socio-cultural aspects and barriers to health and well-being in youth with physical disabilities. While many of these studies focus on describing the physical and emotional well-being of adolescents with disabilities, Boice (1998) indicates that some studies on the health of adolescents with disabilities aim to understand the role of social class and ethnicity on the health of youth. For example, “social class may determine the level of quality of care received and ethnicity may influence the approach to treatment” and language barriers may make communicating with medical professionals difficult (Boice, 1998, p. 936).

A paper by Darrah, Magil-Evans and Adkins (2002), outlines the attitudinal and structural barriers that influence experiences of service delivery in young adults with cerebral palsy. The researchers interviewed and surveyed 88 adolescents with cerebral palsy and their families to determine satisfaction with a number of service delivery areas. In the areas of health and recreation services, it was found that caring and supportive people positively influencing the experiences of youth and their families. However, youth also experienced communication difficulties when dealing with health care providers. Adolescents in this study indicated that service providers used complicated terminology that they could not understand, and/or would talk to their parents only. At times, youth felt excluded from decisions about their own health. In addition, several youth indicated that service providers are often unknowledgeable about their abilities and disabilities. A

lack of disability awareness in general led to barriers to proper health and recreation services.

Research in the sociology of sport and physical activity has increasingly acknowledged the importance of the social model of disability to understanding the sport and physical activity experiences of youth with physical disabilities. DePauw (1997; 2000) has been central to the production of research and theory that privileges a socio-cultural view of disability in sport and physical education research. She suggests that the ways in which physical educators and researchers in the sociology of sport and physical activity view the body, sport and physical activity, has an impact on how disabled or impaired bodies are viewed (1997).

In exploring the ways in which sport may reinforce able-bodied physicality (1997) and physical education may perpetuate ableism (2000), DePauw argues for a transformation in the way disability is understood in the context of sport, physical education and physical activity. Specifically, DePauw suggests that instead of perpetuating disability as a biological category as sport and physical activity researchers have done historically, researchers need to “rethink disability... from a social-historical perspective.” (2000, p. 359). For DePauw, this new mode of thinking includes examining disability as a social construction, focusing on the abilities of people with disabilities, and examining our assumptions and biases about disability and impairment. DePauw outlines a number of methodological considerations for researchers in the areas of sport and physical education embarking on disability research. Specifically, she suggests that in order to better understand disability as a social identity, researchers must undertake research “that is meaningful to individuals with a disability. . . . [and] engage in the

participatory model of research. . . in which individuals with a disability are collaborators in research, not just subjects of passive recipients of research findings” (2000, p. 365).

Despite these recommendations, most research on the sport and physical activity experiences of youth with physical disabilities use either questionnaires or the words of parents, physical educators and health care professionals to study the experiences of these youth (Taub & Greer, 2000). For example, Field and Oates (2001) surveyed 69 parents of youth with physical disabilities in order to determine how important physical activity and recreation were to their children, how thoroughly their children were integrated with non-disabled youth in recreation programs, and what opportunities and barriers to their child’s participation were present. While the findings of this study are important in that they illuminate the difficulties many parents experience finding activities for their children to participate in, and identify the concerns of parents of youth with disabilities, the research findings are not necessarily representative of the concerns and experiences of youth with disabilities themselves.

Recognizing a lack of research available on the physical activity experiences of youth with physical disabilities, Longmuir and Bar-Or (1994; 2000) have developed research aimed at youth with disabilities themselves. Specifically, Longmuir and Bar-Or (1994) used surveys sent by mail to examine the physical activity levels and participation of youth with chronic physical or sensory impairments in Ontario, Canada. Using a modified version of the Canada Fitness Survey, youth identified their physical activity participation level and answered a number of demographic questions.

The authors found a surprisingly large proportion of sedentary youth (29%) in their study, when compared to similar studies with non-disabled youth. This study also

indicated that activity levels for these youth are significantly influenced by age. Specifically, physical activity levels increase for males and females from 6 to 10 years of age. However, after age 15, activity levels decrease steadily in males and more quickly for female participants. Overall, more than 50% of participants in the study indicated that they “felt ‘limited’ in their ability to be physically active... [and a] smaller proportion (41%) felt limited in their ability to participate in peer activities.” (Longmuir & Bar-Or, 1994, p. 173)

In a similar study, Longmuir and Bar-Or (2000) examined factors influencing participation in physical activity among youth with disabilities. The authors collected data using a mail survey sent out to 987 youth aged 6 to 20 years with physical disabilities, chronic medical conditions, and sensory impairments. Overall the study reported that youth with physical disabilities and visual impairments have significantly lower levels of regular exercise. In addition, these youth perceived themselves as “less fit” than their peers, and reported more limitations to participation in physical activity. However, the quantitative nature of this study does not allow for researchers to determine why youth perceived themselves as less fit than their peers, or what “being fit” means to these youth.

The above mentioned studies are an important step towards understanding the health and fitness experiences of youth with physical disabilities. However, the use of standardized questionnaires is not sufficient to capture the diverse viewpoints, experiences and understandings of youth with physical disabilities. More recently, qualitative research methods have been used to begin examining the experiences and understandings of physical activity and sport from the perspective of youth with physical

disabilities themselves. For example, Taub and Greer (2000) utilized in-depth interviews to explore the physical activity experiences of youth with physical disabilities from their perspectives. Researchers recruited 18 male and 3 female adolescents aged 10 to 17 years with a variety of physical disabilities. Semi-structured individual interviews were administered, where youth were asked about their physical activity history and the role of physical activity in their lives.

Using content analysis, Taub and Greer (2000) found that physical activity offered a context within which participants could validate their social identities. Specifically, through physical activity youth with physical disabilities increased their perceptions of their physical abilities and movement capabilities. In addition, physical activity was a place where they could resist stereotypes that their non-disabled classmates held about their disabilities. The social identity of youth with disabilities was also strengthened via physical activity participation in that such participation enhanced beliefs that their impairments were not preventing them from being active. Youth also indicated that participation increased aspects of emotional health such as self-esteem. Secondly, researchers found that physical activity offered a space where participants could interact with their peers and strengthen social ties (Taub & Greer, 2000). Some participants suggested that spending time with friends was an aspect of physical activity that was more important to them than increasing their level of physical fitness.

While concentrating heavily on the positive physical activity experiences of youth with physical disabilities, Taub and Greer (2000) also discuss experiences of physical activity that were considered oppressive to participants. Positive experiences of physical activity were generally associated with spontaneous and unstructured play rather than

physical education class or organized sport programs. On the other hand, disempowering experiences related to being excluded from participation in games during recess, or being prevented from participating in physical education classes “because teachers would not alter sport guidelines or physical activity settings.” (p. 409)

Finally, Taub and Greer describe the physical activity experiences of the youth in their study as “normalizing experiences” (2000, p. 110). Through physical activity, participants discuss feeling more similar to non-disabled peers. The authors state:

Physical activity provides an occasion to increase perceptions of competence, feelings of self-enhancement, interaction opportunities with peers, and social bonding with friends. Such participation represents a socially valued childhood activity and may transcend the significance of a physical disability by accentuating other components of a child’s identity (p. 410).

However, further contemplation of the potential consequences of promoting physical activity as a way for youth with disabilities to be “just like” non-disabled peers is required. Specifically, the discourse of “normalization” has the potential to encourage youth to participate in sport and physical activity in order to become close to the able-bodied norm, instead of using it as a place to challenge narrow and/or oppressive societal views of difference, ability and the body. In fact, Taub and Greer state that “respondents seldom question[ed] the discriminatory treatment of individuals who do not demonstrate physical ability in the typical . . . ways.” (2000, p. 412) Further research is needed to examine if youth with disabilities use the physical activity context as a site to challenge and transform ableist discourses and practices.

In reviewing health and physical activity literature on youth with physical disabilities, it became apparent that there is a great need for qualitative research in this area. According to Wright, MacDonald and Groom, quantitative studies alone “cannot provide information about the place and significance of physical activity [and health] in young people’s live . . . [T]hey cannot demonstrate how young people deploy the discursive and material resources associated with physical culture to construct their identities in relation to physical activity [and health]” (2003, p. 18). The research I reviewed focused heavily on the emotional and psychological health of youth with physical disabilities. However, little is known about how youth construct health and physical activity, or of what importance emotional and psychological health is to such constructions.

Secondly, the literature I examined was indicative of the dominance of medical or tragedy discourses of disability in sport and health research. For example, Boice (1998) regularly referred to youth with chronic disabilities as “victims of these diseases”, suffering the repercussions of disability or illness (p. 928). In addition, the methodologies, language and assumptions of researchers examining youth with disabilities continues to oppress and silence the voices of youth with physical disabilities.

Finally, the prevalence of non-categorical studies may lead health promoters and physical educators to believe that experiences of health, physical activity, sport and well-being in youth with disabilities is universal. Further consideration of social and cultural factors that impact the health status and behaviours of youth with disabilities (e.g. poverty, access to adapted sport and recreation programs/facilities) is also needed in health and physical activity research. Specifically, further studies are required to

understand the ways in which relations of difference such as age, gender, race and sexuality intersect to inform experiences of health and physical activity in youth with physical disabilities.

Fortunately, recent qualitative studies in the areas of sport sociology and physical education are indicative of changing attitudes towards disability and impairment. Specifically, researchers such as DePauw (1997; 2000), Shogan (1998) and others, are beginning to develop theory and methodology that is highly influenced by disability studies, the disability rights movement, and the social/social construction model of disability. It is my hope that future researchers in health and sport sociology will be influenced by these developments and utilize the critiques of DePauw and others to develop innovative approaches to researching youth with disabilities.

Discourses of Health, Fitness and the Body

The recent popularity of terms such as “lifestyle”, “healthy living”, and “wellness” represent an enormous change in the ways that North Americans understand, participate in, and are educated about health and fitness. Over the past 20 years, North Americans have been and continue to be bombarded by messages concerning health and fitness (Howell & Ingham, 2001). Health and fitness programs and research encourage us to take part in regular exercise to decrease our weight, tone our muscles and increase our lifespan (White, Young, & Gillett, 1995). As a whole, these formal and informal messages have fashioned a prevailing discourse around health and fitness. They promote health and fitness as an individual and moral responsibility; a personal duty rather than a social problem (Howell & Ingham, 2001). Similarly, dominant discourses of physical fitness, described by Pronger as “the technology of physical fitness” encourage us to view our

bodies as “biophysical objects” (2002, p. xiii) and to use scientific and technological advances to control our bodies, health and physical appearance.

The physical, social and psychological benefits of participation in regular physical activity are well known within academic literature. In addition, there is a wealth of public and private information, initiatives and programs aimed at improving the health, fitness and overall well-being of Canadians. However, only a small amount of research has examined the problematic nature of dominant discourses of health and fitness in western societies. In addition, little to no research has looked at the effects of current “solutions” to the North American “health crisis” that do not consider the experiences and circumstances of minority groups and communities in North America. Specifically, researchers have overlooked the differing ways that individuals and groups of youth and children may interpret health and fitness programs. As a result, health research, as well as prevalent government and corporate health and fitness programs and initiatives on health and physical activity may be promoting messages about health and fitness that are inappropriate or ineffective when aimed at youth. In addition, it is possible that these initiatives and messages are inappropriate and oppressive and detrimental to the overall well-being of certain youth populations in Canada.

Healthism, Individualism and Morality

Health and sport sociologists and philosophers have begun to address concerns about dominant health and fitness ideology in North America. In response to the popularization of health consciousness within North America, a wealth of critical literature attempting to deconstruct current health and fitness ideology has been published (e.g. Chrysanthou, 2002; Crawford, 1980; Edgley & Brissett, 1990; Howell & Ingham,

2001; Pronger, 2002; White, Young & Gillett, 1995). Such literature is a first step to understanding the ways in which dominant health discourses promote messages and beliefs that assist in maintaining social hierarchies.

Crawford (1980) was the first academic to use the word “healthism” to describe the problematic nature of dominant discourses perpetuated via the modern health and fitness movement. Crawford suggests several important principles underlying the concept of healthism. First, healthism reflects the idea that health is seen as the primary means to achieving well-being. For example, Edgley and Briessett (1990) argue that “health is presumed to underlie all achievement. . . . [It is] the fundamental pre-condition of a successful life.”(1990, p. 258) However, as Pronger (2002) suggests in his examination of dominant fitness discourses in North American society (i.e., the technology of physical fitness), “[while] the technology of physical fitness represents a practical, *modern* way of living life to the fullest. . . . this modern approach to amplifying life’s natural possibilities also limits it.” (p. 9) Pronger (2002) alludes to feminist literature that draws on the work of Foucault to examine physical fitness as an ideology that reinforces gender differences and leads to disordered eating and exercise behaviours in the pursuit “of the ideally fit body” (p. 5).

Secondly, to Crawford (1980), healthism represents a societal understanding that maintaining health and well-being is primarily a behavioural project. Illness or lack of health is promoted as rectifiable through behaviour modifications such as lifestyle changes. To achieve health, the individual must assume a responsibility to “resist culture, advertising, institutional and environmental constraints, disease agents, or, simply, lazy

or poor personal habits.” (Crawford, 1980, p. 368) As such, dominant health discourses promote health as a personal and moral responsibility.

To conceptualize the personal nature of health maintenance, Crawford (1980) developed the notion of “individualism” as a central aspect of dominant health and fitness discourse. The concept of individualism allows academics to conceptualize and reconceptualize the ways in which popular health discourses can inhibit attempts to improve health and well-being in the North American population. For example, White, Young, and Gillett (1995) show that the current emphasis on individual behaviour and volition present within popular Canadian health and fitness discourses allow people to ignore the environmental and structural factors that effect health and reinforce unequal distribution of health related resources. Howell and Ingham (2001) suggest that within the United States, celebrating individualism within dominant health discourses screens the mass population from identifying the failure of the welfare state to improve the quality of life of its citizens, and from critiquing and challenging the contradictory and oppressive nature of the capitalist economic structure. White, Young and Gillett (1995) also argue that participation in “health” and “fitness” practices does not always lead to positive outcomes. “[F]itness-oriented people also get sick--often, ironically, as a result of their fitness regimes. . . . [Furthermore,] the financial and psycho-emotional costs of exercise-related injuries can be as disabling as the [physical] injuries themselves” (White & Young, 2000, p. 56).

Although Crawford’s early work on healthism formed the basis for an expanding body of literature in the fields of health and medical sociology, latter writings concerning healthism suggest that Crawford’s early work may focus on the role of individualism at

the expense of a social understanding of health ideology (Edgley & Brissett, 1990). Specifically, Edgley and Brissett state that research overemphasizing the individualistic nature of current health ideology ignores “the social matrix in which all such movements are imbedded” (1990, p. 259). Instead, Edgley and Brissett propose that dominant health discourses perpetuate responsibility at a societal level. Specifically, messages promoting engagement in a particular lifestyle as necessarily leading to health, lead to the belief that individuals are morally responsible not only for their own health but for ensuring that others are participating in “healthful” behaviours. In other words, the health status of an individual is her own responsibility as well as the responsibility of people around her (Edgley & Brissett, 1990).

Utilizing this “social” understanding of healthism, sociologists have critiqued health discourses that promote health as a moral obligation (Edgley & Brissett, 1990; Howell & Ingham, 2001; White, Young, & Gillett, 1995). Understood as a moral responsibility, health and fitness ideology becomes focused on the rejection of temptations and pleasures (Edgley & Brissett, 1990). In comparing this discourse of morality to religious ideologies, Edgley and Brissett suggest that the construction of certain behaviours such as smoking, sexual promiscuity as well as drug and alcohol use as “sinful” behaviours is a form of social control “disguised as scientific [fact] under the presumably objective umbrella of medicine [and health].” (1990, p. 267) For example, instead of understanding the promotion of physical fitness as a way in which individuals can restore or rediscover their bodies, health professionals may use the science and technology of physical fitness to harness the body’s “energies in the production of social control” (Pronger, 2002, p. 5).

Howell and Ingham (2001) state that the promotion of health as a moral obligation excuses the state from taking responsibility for the well-being of the nation. Through their examination of the *United States Healthy People 2002: National Health Promotion and Disease Prevention Objectives* report, these authors suggest that national health programs are using the “language of lifestyle” to promote a moral philosophy among its citizens. This philosophy requires members of society to maintain health for their own moral benefit, and not be reliant on the state for assistance. Howell and Ingham argue that the “language of lifestyle” redefines issues of “illness, health care and unemployment . . . as issues of private character -- as a failure in individuals who refused to fight the good fight” (2001, p. 330). However, blaming those who are a strain to government dollars overshadows the failings of the welfare state, encourages privatization and consumption, and assists in the development of a hugely profitable exercise and fitness marketplace (Howell & Ingham, 2001).

In a similar paper, Edgley and Brissett (1990) examined the role of moral obligation as an element of healthism that perpetuates unequal class relations. They suggest that current health expectations are presented as attainable to all individuals who express “moral” characteristics such as discipline, control, and will power. However, as represented by the success of an ever-expanding health and fitness industry, living a “healthy life” is a huge financial burden. “[E]ating healthy simply costs more than eating unhealthy. The phenomenal costs of exercising have been well documented. And there is the great expenditure of time involved in keeping fit.” (Edgley & Brissett, 1990, p. 264) These costs are representative of the classist nature of healthism. Specifically, the discourse of moral consciousness that is imbedded in North American understandings of

a “healthy lifestyle” oppress people with lower socio-economic status such as women and other marginalized socio-cultural groups.

It has become clear that Crawford’s (1980) concept of healthism was a catalyst for the development of critical scholarly literature concerning dominant health and fitness discourses in western society. Specifically, the perpetuation of health discourses that promote individual responsibility for health and well-being can be understood as having some negative repercussions, including a decline in the health and well-being of the population. In addition, dominant health discourses in North American society have been critiqued for connecting health with morality. As a result of this connection, predominant health and fitness discourses may assist in the oppression of marginalized social groups who, due to economic and socio-cultural barriers, cannot participate fully in the health and fitness boom.

Healthism, the “Ideal” Body and the “Unhealthy” Other

In critiquing dominant discourses of health and wellness, researchers have begun to realize the centrality of the body in North American health ideology. Specifically, health sociologists and educators have critiqued discourses that equate the presence of a very specific and unrealistic body type with naturalness, healthiness, fitness and desirability (e.g., Chrysanthou, 2002; Goldstein, 1992; Wendell, 1996; White, Young & Gillett, 1995). In addition, Watson, Cunningham-Burley, Watson and Milburn suggest that the ineffectiveness of health promotion strategies may be related to a lack of understanding of “the social and cultural contexts of health, including the body.” (1996, p.161) Goldstein (1992) suggests that in western society, the body has become the symbol of dominant health ideology. Health behaviours center on and around the body in a religious

fashion (Goldstein, 1992). The body is seen as the most natural part of ourselves; a temple that we must care for and protect by participating in regular rituals (i.e. health behaviours). Viewed in this way, messages perpetuated by the current health and fitness movement may be understood as controlling the actions, behaviours and performance of the body. As Watson et al. advocate, “health education can be seen as a means whereby society seeks to impose control over individuals and ‘order’ populations through the promotion of specific forms of health behaviour aimed at controlling bodies” (1996, p. 162).

In his philosophical account of the relationship between the postmodern body and healthism, Chrysanthou (2002) examines the importance of the body as a symbol of naturalness and purity in dominant health discourses. Chrysanthou theorizes that the body is the last place upon which utopia (or perfection) can be attained. The postmodern impossibility of a communal vision of society has resulted in the focus being turned inward to the human body as the place upon which utopia can be achieved.

Chrysanthou’s concept of ‘somatopia’ reflects the idea that “the new emerging map of utopia is the human body: external and internal.” (2002, p. 471) However, as institutions, popular culture and consumerism target the surface of the body as the display case of “somatopia”, the wellness of the inner body becomes important only to the extent that it benefits the appearance of the outer (Chrysanthou, 2002). In other words, the maintenance of a particular body shape has become a symbol to the rest of society that we care about ourselves and about society as a whole (White, Young & Gillett, 1995).

Within North American culture, health and beauty ideals are inextricably linked, emphasizing particular body shapes that are so extreme that attempting to attain them

often leads to disordered eating, compulsive exercising, and other problematic behaviours (White, Young & Gillett, 1995). Ironically, Chrysanthou (2002) and White, Young and Gillett (1995) argue that the health movement has led people to participate in behaviours that decrease biological health and well-being. Chrysanthou (2002) suggests that healthism does not lead to a free or 'utopian' body at all. Instead, the connection of healthism to the attainment of bodily perfection has led to a more anxious and neurotic society. "[A]bsorption with one's health is, rather like pain an incommunicable, and fundamentally antisocial experience. The irony of the utopian body project is that it may actually produce an unhealthy society." (2002, p. 474) In addition, as the body becomes centrally implicated in health and well-being, individuals are pressured to become increasingly focused on themselves and tend to ignore societal concerns and conflicts (Goldstein, 1992).

White, Young and Gillett (1995), take their critique of the constructed relationship between the "ideal" body and health a step further by examining how health discourses that prescribe the attainment of a specific body type are highly gendered. They propose that notions of the "fit" and "healthy" body are deeply entwined with gender oppression. For example, prevailing discourses display the ideal/healthy female body as one whose shape emphasizes slimness and a toned but not overly muscular body. In contrast, the male body ideal emphasizes a bulky physique free of visible fat (White, Young & Gillett, 1995). Such constructions of the male and female body reinforce male strength, power and control while reinforcing passivity and weakness in women. For women, attempting to attain a "perfect", "healthy" body may lead to feelings of inadequacy and loss of control. The increasing narrowness of the "ideal" female body has also been related to the

onset of eating disorders and obsessive exercise (Bordo, 1990). As women are increasingly encouraged to regulate their bodies in order to achieve healthiness and beauty, decreasing the size of the female body also means it is going to be more easily dominated by others (White, Young & Gillett, 1995).

Theoretical writings by sport and health sociologists have identified the many ways in which healthism perpetuates discourses about the body and health that oppresses marginalized social groups in different ways (see White, Young & Gillett, 1995 for an examination of the classist nature of healthism). Furthermore, a number of researchers have looked at the ways in which healthism equates a particular body shape, size, and weight with “good” health and well-being (e.g., Beausoleil, 1994; Watson et al., 1996). Unfortunately, less research has examined how the association between health and the “ideal” body may perpetuate ideas about disability and the body that are extremely problematic. Research and theorizing around healthism need be more attentive to the ways in which ableist discourses underlie healthism.

Health promotion initiatives that perpetuate or support healthist discourses may be particularly problematic for people with physical disabilities and/ or chronic diseases. Healthism idealizes the non-disabled body and promotes a specific “ideal” body as attainable through hard work and self-control. As a result, healthism associates the ill, impaired, and non-ideal body with deviancy, laziness, and moral laxity. Crawford (1994) suggests that the presence of the “unhealthy other” figure is in fact necessary for the health and fitness movement to be successful. By blaming the victim, it becomes easier to socially distance oneself from the idea that ill health or impairment is a result of external circumstances or misfortune. Instead, the presence of an ill or impaired body is

understood as a consequence of poor behaviours and moral laxity on the part of the body's owner. As Crawford has stated:

The sick are not only made responsible for their illness, they are also made different. The person who is momentarily free of illness is thus reassured; s/he is not like those who are sick. Thus, the tacit assumptions so frequently heard in everyday conversations: 'He has lung cancer.'/ 'Is he a smoker?' or 'He was injured in an auto accident.'/ 'Was he wearing a seat belt?' (1994, p. 1356).

As such, the presence of the unhealthy other allows society to buy into the ideals of personal and moral responsibility.

Crawford (1994) and others (e.g. Farr, 1995) have critiqued the role of "victim blaming" discourses in the reproduction of negative discourses surrounding chronic illnesses and disease. However, an examination of how images of the physically disabled body are represented within dominant health and fitness ideology is largely absent from health and sport sociology research. Fortunately, recent attention to the body within the field of disability studies allows for some understanding of western society's "cultural obsession" with preventing "health problems" (Stone, 1995). Specifically, health discourses that equate the "ideal" healthy or fit body with morality have been critiqued for perpetuating disempowering images and understandings of people with physical disabilities (Butler, 1998; Stone, 1995).

Traditionally, health has been associated with the absence of disease. Based on this understanding, the disabled/ impaired body is prevented from being considered healthy (Brandon, 1990). A physical impairment becomes something that must be overcome or

fixed in order for a person to reach a “normal” state of feeling and being. Furthermore, Tighe argues that the idealization of health as a person’s “ultimate commodity” results in persons with physical disabilities being conceptualized as chronically sick and unhealthy regardless of how they feel about their own health and well-being (2001, p. 511). Therefore, it is not surprising that that many health initiatives aimed at people with disabilities attempt to normalize/cure the disabled body.

Davis (2002) suggests that there remains a strong pressure on people with physical disabilities to “overcome” their impairment and normalize their bodies through medical interventions and prosthesis. Participation in health and fitness practices may simply be another way in which people with disabilities are encouraged to discipline and work their bodies to meet a level of functionality and appearance that is closer to the able-bodied “norm”. In addition to upholding negative messages concerning the normality and acceptability of the impaired body in western society, researchers have found that people with physical disabilities often experience multiple and extremely painful interventions and therapies as children and youth aimed at normalizing and correcting the “problem” with their body (Barron, 1997; Middleton, 1999). In addition, Davis (2002) suggests that by pathologizing the physically impaired body and focusing on the individual to “correct” the impairment, health and medical discourses have deterred people with disabilities from identifying with other disabled people, which makes collective political organization and action difficult to achieve.

As argued earlier in this section, dominant health ideology normalizes the appearance of a particular body as healthy and morally good. Bodies that do not fit “the norm” are pathologized (i.e. considered unhealthy and immoral). Featherstone argues:

“With appearance being taken as a reflex of the self the penalties of bodily neglect are a lowering of one’s acceptability as a person, as well as an indication of laziness, low self-esteem and even moral failure” (cited in Stone, 1995, pp. 419-20). Butler (1998) and Stone (1995) acknowledge that equating a particular body with morality is extremely oppressive to people with disabilities whose bodies are viewed in opposition to the “ideal” body. Specifically, in her examination of youth and disability culture, Butler (1998) describes how equating of the body’s appearance with morality can lead to negative understandings of people with disabilities. She states:

Beauty has for centuries been seen as good, whilst ugliness or abnormality has been related to evil. . . . Failure of an individual [with a disability] to look after their body has been related to a lack of morality and self discipline (p. 89).

Youth with physical disabilities may at times display certain bodily movements such as “spasmic” movements of the arms and/or legs that make non-disabled people uncomfortable (Butler, 1998). Shakespeare (1994) suggests that in this way, disability is seen to represent the physicality and “animality” of the human body. Such “imperfections” in the appearance of the body may be perceived as a symbol of moral failure (Stone, 1995). Discourses such as healthism, which promote specific behaviours aimed at controlling the body, reinforce a moral obligation to not giving into the body; that an uncontrollable body is a symbol of a weak or immoral mind. Problematically, connecting the “perfect body” with “perfect morality” suggests to people with disabilities that to be a moral person, they need to have control over all movement at all times (Stone, 1995). In many cases, this is not a possibility.

The concept of healthism is a framework for the deconstruction of health and fitness discourses that embrace individualization, health as a moral obligation, and health as represented by a specific body type. In today's society, we are increasingly encouraged to focus inwardly and blame only ourselves for anything less than "perfect" health and the "perfect" body and we internalize and naturalize these discourses. As a result, those unable to meet socially constructed understandings of "healthiness" and the "ideal" body tend to be blamed for their unhealthy conditions or stigmatized for being a burden on social services. Overall, dominant health discourses justify the unequal distribution of health practices and knowledge, and perpetuate negative images and understandings of physical disability.

Texts of Health, Fitness and Dis/ability

Early research on healthism attempts to name and deconstruct the multiple sources and sites of dominant health discourses. Specifically, critical sociologists interested in health, sport, and physical education such as Lupton (1992) suggests a number of sites and institutions perpetuating healthism. Lupton located communications between doctors and patients, conversations between members of various social populations, government health promotion initiatives, mass entertainment and the news media, and medical and public health texts as places where healthism was being perpetuated. In his examination of technologies of physical fitness, Pronger referred to "scholarly scientific papers. . . academic textbooks on the sciences of physical fitness; manuals for exercise and dietary regimes; and popular books on physical fitness, as well as magazines and audio and video tapes dedicated to physical fitness" as texts perpetuating the technology of physical fitness (2002, p. xv). In addition, Pronger named

fashion magazines, cyborg movies and even pornographic videos as contributing to the idealization of a specific body as healthy, fit, “normal” and attractive.

Scholars in the field of disability studies (e.g., Barnes, Mercer & Shakespeare, 1999; Corker & French, 1999) have begun to examine texts as sites within which oppressive discourses of dis/ability are developed and perpetuated. Many of the same sites, texts and institutions examined by researchers interested in healthism perpetuate ableism through the use of discourses linked to individual or medical understandings of disability. While youth with physical disabilities may draw from a multiplicity of cultural texts, lived experiences and discourses, this section attends to the areas of medicine, rehabilitation/physiotherapy, popular health and fitness texts, as well as (adapted) physical education. I have chosen these areas to focus on because they are places where health, fitness and the body are regularly discussed. They are also institutions/sites/texts that youth with mobility impairments are in regular contact with.

Healthism, Ableism and the Health Sciences. The influence of the health sciences, or more specifically medicine and the multiple areas of scientific research that underlie it, on understandings of health and the body is a topic of interest in a variety of subject areas. As Cartesian knowledge led to a conceptualization of the mind and body as separate (Crawford, 1994), and modern developments in science and technology led to knowledge about the physiological and psychological make-up of the body, the medical sciences became leaders in attempts to maximize the productivity and efficiency of the body. In unlocking the human body, Crawford (1994) suggests that “health” became a concept for describing the “normal” state of the body. “Thus, in unlocking the secrets of the body, medical science claimed to have discovered the laws of health.” (p.1350) As

such, the health sciences have become “the business of reconstituting normality and health” (Scully, 2002, p. 48).

The use of medical language in the discursive construction of health and fitness is an important concern to academics studying healthism and discourses of disability. In fact, the medicalization of health and illness is a major theme underlying Crawford’s earliest work on healthism. Crawford (1980) argues that medical professionals regularly judge and diagnose behaviours. Traditionally, it has been the role of doctors and other medical “experts” to define deviance in eating, drinking, work, leisure and other behaviours. The perpetuation of medical discourse and the legitimacy given to this profession make it likely that the beliefs of medical profession have resulted in specific social understandings of health and illness being constructed by lay people. Crawford (1980) was particularly concerned with the presence of medical terminology within “holistic” health and lifestyle discourses. He suggests that the centrality of this language was indicative of the power of the medical field to set boundaries around the ways in which we think about and practice health and illness in North American society.

However, as Pronger (2002) argues, the prestige and legitimacy granted to the medical sciences is based not only on its status, but its effectiveness at changing the way the world understands the “reality” of the body. Some academics are critical of the health and exercise sciences “because of the way in which they attempt to actually produce the body and its politics.” (Pronger, 2002, p. 6) The health and exercise sciences convey ideas about health as individual, and about the body as a machine or object, which do not reflect the variety of ways in which health and the body are experienced (Pronger, 2002). For example, the dominance of medical and “scientific” understandings of health and

fitness leads to the marginalization of social and environmental discourses of health and fitness (Pronger, 2002).

Pronger (2002) is particularly critical of the role of exercise science in limiting how we understand our bodies and therefore what we do with them. He proposes that “[t]he exercise sciences are in the most fundamental way engaged in trying to change the reality of the body, to make it function more productively and efficiently.” (p. 130) For example, research in the area of biomechanics tends to contextualize the body as mechanical and measurable. Similarly, “exercise physiology understands the body to be an object not unlike any other object, formed by particular operations of chemicals, all of which have molecular and atomic structures that govern their operations.” (Pronger, 2002, p. 131) By assigning value to the body and constructing the body of measurable, exercise physiology and biomechanics are “driven by the practical quest to control physiological processes in order to increase their efficiency by the optimal organization of the body’s energy through diet and physical training” (Pronger, 2002, p. 131).

Scholars in the area of disability studies and adapted physical activity are particularly concerned with the ways in which the health sciences (particularly the rehabilitation sciences) produce the body, and effect discourses and understanding of dis/ability. These scholars problematize the role of the health sciences in perpetuating the notion of health and well-being as exemplified in the perfect body (Morse & Johnson, 1991). Tighe (2001) critiques the medical model’s construction of health. She argues that under this model, the degree of one’s health is determined by “how deviant one’s body is from the norm” (p. 512). As such, people with physical impairments represent “an unqualified deviation from the normative health standard” (Tighe, 2001, p. 512).

Stone (1995) examined the role of medicine and specifically rehabilitation as creating discourses of health and fitness that are particularly problematic for people with physical disabilities. Specifically, Stone argues that medical understanding of the body have led to understandings of all bodies as potentially fixable. As such, disability is seen as temporary-- recovery from impairment as possible through hard work. This rehabilitation ideology is reinforced by dominant health discourses which emphasize notions of personal and moral responsibility for the well-being of one's body. "[T]he medical/educational rehabilitation model focuses on deficits, is driven by experts, and promotes fix or change of the individual" (DePauw, 2000, p. 360). As such, persons with physical disabilities are pressured to conform to the paradigms of the rehabilitation sciences. Through "hard work" and "dedication", these discourses encourage people with disabilities to "normalize" their bodies (i.e. train their bodies so that they can more easily "pass" as non-disabled).

Unlike the childhoods of non-disabled youth, youth with disabilities often take part in physiotherapy and rehabilitation and a part of their regular and sometimes daily lives. The messages that youth with disabilities receive at the site of physiotherapy and rehabilitation may have important implications in their understandings of health, their bodies and their identities. Some disability scholars are particularly concerned with the effects of rehabilitation ideology on youth's understandings and acceptance of disability and their bodies (e.g., Middleton, 1999; Stone, 1995). Rehabilitation ideology purports that thanks to medical advances, people can overcome their physical impairments through hard work and will power (Stone, 1995). However, focusing heavily on "fixing" children with physical disabilities may be a particularly problematic and oppressive discourse to

youth with disabilities themselves. However, little research has examined the experiences of youth with disabilities with respect to their experiences of physiotherapy and rehabilitation. The few studies that have been conducted on the daily experiences of youth with physical disabilities indicate that physiotherapy is an influential and often oppressive childhood experience, at times, having negative consequences on youth's sense of identity. For example, the youth in Middleton's study indicated that physiotherapy was a place where they experienced feelings of not being in control. Physiotherapy "was experienced as concentrating on the 'fault' to the exclusion of the child as a whole person, growing up with a range of needs" (1999, p. 18). One participant noted:

I hated physiotherapy, moving my limbs about. I couldn't see an end to it. I was put in splints to straighten my legs, like callipers. I stood up all day; it was like a table on my back. I had to eat my dinner like that. Somebody put me in it. I was strapped in it. I couldn't get out of it myself. I had no choice whatsoever. . . . It was painful and demoralizing. . . . At thirteen the only way I could get control over my body was to get anorexia. . . . They never picked up I was ill or unhappy, they were pleased I was losing weight (Middleton, 1999, p. 18).

Although Middleton does not attend to discourses of the body or "normality" in her study, the experiences of physiotherapy described by the participants suggest that physiotherapy is a site where "experts" perpetuate a discourse of disability as abnormal and fixable through hard work and technology. As suggested through the words of one participant, physiotherapists may equate health and well-being with how close to "able-bodied" the participant can become. Emotional and psychological well-being such as

happiness and feelings of being in control of are overlooked in favour of normalizing physical differences. As Middleton argues, “treatments are not aimed at making the child happy, sociable, well or even comfortable but at moulding them towards *physical acceptability*. This is part of the continuum leading toward the myth of physical perfection which oppresses many people” (1999, p. 41; emphasis in original).

A similar study by Barron (1997) examined experiences of adolescence in a group of young women ages 17 to 22 with a range of physical disabilities. Interview data indicated that rehabilitation professionals and other medical professionals focused heavily on getting these children to walk in attempt to have their bodies function more similarly to non-disabled youth. The participants in this study discussed that pressure placed upon them by medical professionals to learn to walk and indicated this as an oppressive and often painful experience. One participant even described “being allowed to first use a wheelchair and not having to attempt learning to walk any longer as a feeling of liberation and increased control” (p. 228). Overall, discourses of normalization dominate understandings of wheelchair use as a way in which youth can gain independence and gain greater control of their lives.

Barron (1997) explores the ways in which experiences of physiotherapy and rehabilitation are gendered and particularly oppressive to young women and girls with physical disabilities. She argues that:

[T]he everyday lives of physically disabled girls/women involve a great deal of physiotherapy treatment which aims at ‘correcting’ and ‘making whole’ their bodies. . . . This means that disabled girls from an early age are, although not explicitly told that their bodies need ‘repairing’. The early focus

on training for more 'normal' body-functions involves internalizing a view of their bodies as not 'normal' (p. 230).

A discourse of health as equated with physical "normality" or able-bodiedness was apparent in stories of physiotherapy by youth and particularly young women with physical disabilities. By focusing on "correcting" their bodies, youth with physical disabilities may develop an understanding of their body as not whole or normal. However, it is likely that youth resist oppressive discourses of their bodies and health perpetuated through the physiotherapy or rehabilitation setting. Further research is required to examine how youth with physical disabilities interact with discourses of the body and health as perpetuated by the medical field.

Pronger (2002) suggests that an understanding of the health sciences as a politically motivated competitive marketplace is overshadowed by its role in producing increasingly accurate, specific and "truthful" information about the human body. The health sciences are politically and financially motivated to institutionalize exercise in the prevention and treatment of obesity, diabetes and other diseases. The health sciences have great interest in gaining control of the health and fitness industry. By claiming expertise in the areas of health, fitness and the body, the exercise sciences are influential in the development of government health promotion programs as well as various popular health, fitness and exercise texts. For example, "exercise scientists and sports physicians [attempt] to gain greater control over the health care industry by leveraging national policy on health care, which operates powerful institutional controls on the conduct of human life and health.... [As such,] [i]t is the applicability of the exercise sciences, their power to inform human practice, that makes them meaningful and keeps them funded." (Pronger, 2002, p. 130)

Furthermore, although a multi-disciplinary field, the exercise sciences do not extend beyond the physical sciences (Pronger, 2002). “[E]xercise science does not extend beyond the physical sciences and the uncritical psychological approaches of behavioural, functionalist, and physiological psychiatry. The critical research of the sociology, anthropology, and history of sport and exercise...has virtually no place in the exercise sciences.” (Pronger, 2002, p. 131) Instead, the exercise sciences tend to perpetuate an individual, modernist and biological understanding of health and exercise. Alternative discourses of health and critiques of dominant health and fitness ideology such as those developed by Crawford (1980) and Pronger (2002) are not included in research publications or scientific exercise prescription and fitness manuals.

Healthism, Ableism and Popular Health and Fitness Texts. Fitness magazines, television and infomercials perpetuate particular health and fitness discourses that equate transforming the shape of one’s body to achieving health and fitness. White, Young, and Gillett (1995) suggest that dominant discourses of health and fitness perpetuated by the health and fitness industry and popular media, are reflected in the growing presence of obsessive body building practices, use of steroids and other drugs, and problematic dieting and consumption behaviours. Western society’s obsession with health and fitness as equated to the “ideal” body, has contradictorily led to unhealthy and dangerous behavioural practices (White, Young, & Gillett, 1995).

Pronger (2002) deconstructed popular representations of the “fit” body in North America. He suggests that while putting the fit body on display is not a new phenomenon, the commodification and mass production of the fit body as an “artefact of consumer culture” is (p. 143). In examining the presence of the fit body on billboards, in

advertisements, in the fashion industry, on television, in movies, and in magazines, Pronger argues that the overwhelming presence of the fit body in North American culture frames the way people read bodies. The popular media deals with the consumption of fit, bodies sculpted to meet hegemonic expectations of femininity and masculinity (Pronger, 2002).

Nichter and Vukovic (1994) used ethnographic interviews to examine weight-preoccupation in adolescent girls. Researchers found that the media was a strong influence on girls' constructions of body weight. For example, one participant indicated that teen magazines provided useful tips on weight management and weight loss. However, she also indicated that these discourses were problematic "because then it's like 'Am I fat?' And then I start saying, 'Hmm, maybe I can lose weight.'" (p. 123) Disguised as self-help articles and advertisements, the authors indicated that these magazines conveyed the message that physical beauty paves the road for happiness and attracting males.

Nowhere is the commodification of fit and healthy bodies more apparent than in popular health and fitness texts. Utilizing knowledge produced by the health and exercise sciences in varying degrees, health is promoted as acquirable by purchasing the right products and/or services (Farr, 1995). In his examination of popular fitness texts, Pronger (2002) notes the dominance of popular fitness texts in perpetuating the technology of physical fitness. "Their power [he suggests,] comes from their consumer appeal, market orientation, practicality, and immediate applicability to the everyday lives of their target consumers." (p. 136) However, as MacNeill (1998) and Pronger (2002) both acknowledge, such these texts draw variably from the exercise sciences, and often

promote weight loss and fitness programs that are in fact dangerous for the body. In addition, many of these texts perpetuate healthism, consumerism and limited notions of the fit and healthy body.

MacNeill (1998) deconstructed and reconstructed three popular North American celebrity workout videos. Within these videos, MacNeill uncovers contradictory discourses of healthism, heterosexual attractiveness, and consumerism. MacNeill argues that these videos tend to equate decreases in body mass with increases in health. In fact, “[t]he celebrity fitness video image of health is an unhealthy underweight state” (1998, p. 176) In addition, MacNeill reveals that many of the exercises within these videos are physically dangerous or harmful, and that exercise obsession is perpetuated as positive rather than problematic and dangerous.

Furthermore, these videos are heavily critiqued for perpetuating sexist stereotypes and perpetuating a discourse of the female body as an object of consumption. Using professional models and actresses whose bodies represent the “ideal” in heterosexual female beauty and body shape, “[t]he viewer is invited to remake her body and live alongside her chosen icons of gendered leadership” (MacNeill, 1998, p. 181). Fitness is not presented as a form of movement that is pleasureable and may increase cardiovascular or muscular fitness. Instead, “[t]he lesson offered is that women’s bodies are to be whittled via fitness for the purpose of being visually consumed by others” (MacNeill, 1998, p. 175).

Following the arguments in this literature, it becomes apparent that celebrity videos perpetuate discourses of health, fitness and the body (particularly the female body) that are extremely problematic. However, in using Foucault, MacNeill (1998)

acknowledges that celebrity workout videos can be reinterpreted and resisted by their audience. “The workout video can be used to celebrate joyful movements alone or socially, and possesses the potential for offering activity as a resource for health and pleasure.” (p. 181) Similarly, youth are not passive victims of these discourses. Youth “do not passively absorb cultural products and images of popular culture; audience members actively make sense of and take up these images for specific purposes, in specific situations, and under specific conditions” (Beausoleil, 1994, p. 35).

However, empirical research is required to examine how dominant discourses emerging from popular health and fitness texts are taken up, understood, reinterpreted and resisted by their audience. As Beausoleil (1994) explains in her critique of feminist deconstructions of popular media, the “concern with media, images, and representations ignores how women actually engage with these ideals in their daily practices. Research on images and representations offer speculations about the psychological effects of ideal images of women; it does not account for women’s lived relations to these images” (p. 34).

While current research on dominant health, fitness and bodily discourses perpetuated via popular health and fitness texts have examined the gendered and sexist nature of such texts, future research is required to examine the ways in which these texts perpetuate discourses that are oppressive to people of a variety of marginalized positions such as women of colour and women with disabilities. As Barron suggests in her examination of gender roles in the experiences of young women with disabilities, “images portrayed of the ideal woman via media are not those of wheelchair users. Instead, physical ‘perfection’ and fitness are subject to an idealization” (1997, p. 231).

However, discourses do not operate in a vacuum. Barron's study indicates that stereotypes concerning "ideal" feminine (i.e. heterosexual) beauty intersected with discourses of the disabled body to inform how these young women perceived their own physical attractiveness. Future research is required to explore the ways in which ableist discourses are perpetuated alongside health and fitness discourses within popular health and fitness texts. Empirical research should address the effects of these discourses on constructions of health and fitness among people with physical disabilities.

Disability scholarship may be a useful area to turn to for future investigations of popular health and fitness texts. These scholars have made great strides in the area of media studies, uncovering the ways in which the media perpetuates a narrow and oppressive view of the body, and tends to render invisible the physically disabled body (e.g. Barnes, 1992; Butler, 1998; Sutherland, 1993). As Davis so accurately states:

[D]isability occupies a different place in the culture at this moment. . . . Every week, films and television programs are made containing the most egregious stereotypes of people with disabilities, and hardly anyone notices Newspapers and magazines barely notice the existence of disability and largely use ableist language and metaphors in their articles. In other words, disability may be the last significant area of discrimination that has not yet been resolved (2002, p. 150).

Healthism, Ableism and (Adapted) Physical Education. Canadian physical and health education classes act as sites through which particular discourses of health, fitness and the body are perpetuated. Hargreaves (1990) proposes that within the school setting, physical education plays a particularly dominant discursive role, being the only subject

(other than religion) that focuses on social integration and the development of self-control through body work. As such, the physical and health education classroom, teacher and curriculum are sites of particular concern to researchers interested in healthism. A number of studies conducted in Australia during the mid 1980s and early 1990s targeted physical education as a site through which healthist discourses are supported (e.g., Hargreaves, 1990; Kirk & Colquhoun, 1990; Tinning, 1985). Hargreaves (1990) suggests that physical education acts to socialize and socially control the youth of western society. Through teaching acceptable behaviours and focusing on emotional and psychological development, physical education performs the function of preparing youth to fit into the existing structure of society. As such, Hargreaves proposes that healthist discourses are in line with the objective of physical education—the creation of self-controlled citizens responsible for their own well-being.

Hargreaves (1990) does not acknowledge that the physical education classroom is only one of several sites within which healthism is promoted. In addition, she overlooks the idea that media and government initiatives influence physical education. However, what is clear from her research and the research of others in this field, is that messages sent out by physical educators since the rise of health-oriented physical education are problematically supporting healthism. The physical education teacher, the physical education curriculum, and the implementation of the curriculum into individual schools have been examined as sites within which discourses of individualism, the blurring of health with morality with the “ideal body”, and the exercise=fitness=health triad are uncritically adopted and promoted.

Tinning (1985, 1991) and Wright (2000) argue that the physical education profession has vested interest in perpetuating healthism. By focusing on fitness as a necessary producer of health, physical activity classes are essential to the overall and lifetime health and well-being of children. In addition, the legitimacy of physical education has been supported historically by the movement sciences. The adoption of a scientific rather than sociological understanding of physical activity is central to justifying the importance of physical education. Tinning (1991) proposes that it was only when a scientific and biological approach to physical education was developed in the 1970s and 80s (what he calls “health oriented physical education” or HOPE) that the government and community began to consider physical education as relevant to the needs of society as a whole. Simply, as medicine and science increasingly discuss the problems of cardiovascular diseases and other disorders related to a “sedentary lifestyle”, physical education professionals realized that the physical education class could be an important site for raising public consciousness and providing a “solution” to health concerns (Tinning, 1991).

A deeper examination of the HOPE “solution” reveals that these programs regulated and naturalized individualism and viewed the surface of the body as an indicator of health status and morality. Tinning (1991) suggested that innovative programs such as Health Related Fitness (HRF) in Britain, and Daily Physical Education in Australia promoted healthism by focusing narrowly on changing individual behaviours such as taking up daily fitness activities and educating students on the correlation between diseases and diet, smoking and consuming alcohol. While these messages are well warranted on their own, problematically, these programs excluded a critical view of

dominant health ideology. Tinning also argues that HOPE programs fail to challenge the ways in which health ideology blurs distinctions between body shape, health, fitness, youth, sex appeal, morality and disease prevention. As such, physical education teachers often naturalize ambiguous messages found within healthism. Health is promoted through physical education as both “control” (the attainment of health through discipline and determination) and “release” (health as leading to enjoyment and a positive state of mind).

However, these conflicting discourses and the ways in which they intersect with relations of difference such as race and class have not been examined within the context of physical education. For example, physical educators may not consider the idea that children of families with a lower socioeconomic status may understand good health in terms of “release” because the work lives of their caregivers are more likely to be associated with control and discipline (Tinning, 1991). Without an understanding of the socio-cultural context of a student’s life, physical educators may blame the student (implicitly or explicitly) for his or her failure to embody dominant health ideology.

Colquhoun (1991) examined the various physical education objectives aimed at secondary school physical education classes in Great Britain during the late 1980s. He found that health based physical education focuses highly on prevention, behaviour modification, and personal control, while socio-cultural aspects of health, lifestyle and illness are overlooked. For example, Colquhoun discusses the problematic presence of individualist discourses present within physical educational materials such as the “Body Owners Manual.” Implied through the use of a car as an analogue to the human body, this widely distributed document focuses on the importance of self-responsibility and

control in acquiring and maintaining “good” health. Within this discourse, the body is portrayed as mechanistic, and health as maintainable through self-responsibility and development of healthy habits. Health becomes the product of good maintenance just as a car that receives regular tune-ups and ample oil and gas. Further, individuals are warned that failure to regularly maintain their body will lead to one that is ill and undesirable. However, as Tinning (1991) suggests, it is unfair, unethical, and unrealistic to expect students to change their behaviours simply because they have gained knowledge, just as it is highly detrimental to a child’s self concept to assume that failure to adapt certain behaviours indicates one’s lesser morality.

In resistance to “blaming the victim” health discourses, Tinning (1991) supports the need for physical educators to develop a better understanding of social factors and power relations that mediate personal behaviour. By developing an understanding of these relations, the unequal distribution of health across the population becomes a societal rather than strictly individual “problem”. Furthermore, Tinning (1991) suggests that school physical education programs that do not challenge “the media purveyed images of health and fitness [nor relate] daily fitness sessions with the contexts of [students’] home life, indicates to [Tinning] that the school is implicated in reproducing notions of a healthy lifestyle which are ill-conceived and lacking in contextual reality” (1991, p. 10).

Kirk and Colquhoun (1990) are also critical of the health and fitness discourses being perpetuated through physical education classes and curricula. These researchers illustrated the ways in which the “Daily Physical Education Program”, a commercial curriculum package widely used in primary schools in Queensland, Australia promoted healthism through a variety of discourses. They suggest that health discourses associated

with this particular program were perpetuated at a variety of sites; through the writers and publishers of the curriculum, the education department who supported its use within the school system, and the actual schools and teachers who implemented the program. As a result, no site could be identified as the single producer of knowledge. However, while the authors argue that the meaning of the physical education curriculum is augmented as it goes through the system, they also suggest that healthism, and specifically the exercise=fitness=health triplex are supported at each of these sites.

There is an established physiological relationship that exists between exercise and the development of particular aspects of physical fitness. However, as Kirk and Colquhoun (1989) suggest, health oriented physical education rests on an artificially strong relationship between exercise, fitness and health. The exercise=fitness=health triplex refers to the belief among some educators that participating in exercise as a means of mediating one's fitness level leads to health, "and that being fit and having a slender body is *proof* of health" (Kirk & Colquhoun, 1990, p. 89; emphasis in original). For example, the curriculum and program writers focused on developing both physical skills and fitness through vigorous physical activity. This discourse took priority over other meanings of physical education such as play, sport, and creativity.

At the level of the physical education teacher, (the "generalist" teacher in primary schools), the curriculum documents were interpreted in such a way that fitness and skill categories were divided. However, it was found that many of the teachers lacked confidence in skills teaching and therefore only promoted fitness activities such as aerobics and jogging. As the teachers rarely questioned the belief that fitness leads to health and lacked confidence in teaching skills, fitness became the most (or only)

important component of regular physical activity. As a result, the reinterpretation of the curriculum to suit the interests of the teachers resulted in perpetuating the dominant discourse in favour of the exercise=fitness=health triplex.

In addition to perpetuating the triplex, the prominence of fitness-type activities may alienate youth who do not enjoy strenuous exercise such as running. In an empirical study of young women's perceptions of physical activity and physical education, Sleaf and Wormald (2001) found that their participants regularly had negative experiences in physical education. Specifically, the young women indicated that they disliked physical education activities that required high levels of exertion such as running and fitness tests, and that the physical activities they were interested in were not included in the physical education curriculum. Sleaf and Wormald concluded that physical education classes might support an inaccurate message that only vigorous physical exertion leads to health benefits.

The exercise=fitness=health triplex was not the only problematic ideology found by Australian researchers. For example, Tinning (1985) has suggested that physical education teachers are involved in the perpetuation of what he names "the cult of slenderness". His theoretical paper suggests that physical education teachers may reinforce feelings of inadequacy and isolation in "overweight" children. It is his belief that physical education teachers link "good" health with morality and tend to understand health as located on the external body. As such, they are relatively intolerant of various body shapes. Specifically, Kirk and Colquhoun (1989) found that physical education teachers tended to consider being overweight as an indicator of unhealthiness, poor fitness and moral laxity. "The moral imperative to be slender [was] clearly expressed in

these teachers' comments; to be fat implies loss of control, impulsiveness, self-indulgence, sloth . . ." (p. 430). In addition, Tinning suggests that physical education teachers have a "greater affinity with students who conform to an 'athletic image'. . . [thereby perpetuating an] unidimensional acceptable body type" (1985, p. 12).

As discussed above and in previous sections, the equation of an ideal body with health and morality is a particularly problematic discourse for those whose bodies do not conform to this ideal. Based on Tinning's work, it is possible that the physical education context perpetuates discourses of health and fitness that are unlined by a narrow understanding of the body and ability. However, the ways in which healthism and ableism play out in the physical education setting and are experienced and understood by youth with physical disabilities has not yet to be examined. As Goodwin and Watkinson note, "[w]hat students think, feel, and know about their participation in physical education has received little attention conceptually or in the empirical research" (2000, p. 144-145).

The historical exclusion of youth with disabilities from mainstream schools and classes means that traditional physical education doctrine and teacher training programs may not meet the needs of students with disabilities (Churton, 1986). As Davis and Watson note, "the shift to inclusive education . . . has not necessarily been complemented by a shift in thinking" (2001, p. 677). As such, it is not surprising that researchers have uncovered ableist discourses and practices being perpetuated through the physical education classroom and curriculum. For example, in her study of the high school experiences of young adults with physical disabilities, Middleton (1999) suggested that bullying from physical education teachers was a recognizable occurrence. One participant

described “[o]ne gym teacher [he] hated. [The gym teacher] was bawling ‘get up the ropes’ you know. [The participant] said ‘well I can’t, can I? Look at me!’. [The participant] just sulked in a corner” (p. 11).

Goodwin and Watkinson (2000) examined the physical education experiences of 9 students with physical disabilities in grades 5 and 6. The researchers used a phenomenological approach including focus group interviews and drawings to uncover the experiences of inclusive physical education from the perspective of the students. Several interesting findings were revealed through data analysis. Specifically, the students tended to recall physical education experiences in a dichotomous manner. Students experienced both “good days” and “bad days” within the physical education setting. Themes surrounding negative experiences of physical education included social isolation and restricted participation. For example, students indicated experiences of social isolation when peers laughed at them, called them names or ignored them during physical education. Similarly, Butler (1998) indicated that participants in her study experienced anger when non-disabled peers isolated them from participation in sports and games because they had predetermined (wrongfully) that the individual would be unable to participate.

Physical barriers and restricted participation were also associated with negative experiences of physical education class. Specifically, participants in Goodwin and Watkinson’s study (2000) indicated that physical education teachers inhibited participation in physical education class because they lacked knowledge about adapted physical education and/or about the capabilities of student to perform certain activities. In addition, physical barriers such as classes taught outdoors on grass fields or in

inaccessible areas such as stage in the school auditorium physically isolated participants from the rest of their classmates (Goodwin & Watkinson, 2000).

The physical education setting is unique to other educational settings as it is a site within which body awareness is greatly heightened. For example, Goodwin and Watson explain that “the gymnasium afforded heightened awareness of their [participants’] bodies. They could not for example, minimize the conspicuousness of their wheelchairs as is possible when working at a desk or table in the classroom. Due to its stark openness, the gymnasium exposes its inhabitants to the full view of others. [For the participants of this study], being observed or “stared at” reminded them that their bodies were different from that of their classmates. This reminder contributed to feelings of self-consciousness and transpired into feelings of ambivalence about physical education in some circumstances” (2000, p. 156).

In this way and others, the physical education class can be particularly oppressive to youth with physical disabilities when peers and even teachers have negative perceptions of “different” bodies. As indicated in this section, at times, the physical education class becomes a site within which youth with physical disabilities are ostracized. Awareness that one’s body is being perceived as an object of attention can act to isolate youth with physical disabilities from their classmates (Goodwin & Watkinson, 2000).

However, while physical education class was a site of heightened awareness of the body, it also was a place where youth with physical disabilities may demonstrated skill and ability to classmates. For example, one participant indicated that within physical education class, he was given the opportunity to showcase his wheelchair basketball

skills for his classmates. Such experiences led to increased confidence in athletic ability and in many cases positive acknowledgement from classmates (Goodwin & Watkinson, 2000).

Interestingly, Goodwin and Watkinson (2000) equate instances where participants articulated the health and fitness benefits of physical education with positive experiences of physical education or “good days”. For example, some participants identified physical education class as a place where they could increase fitness and maintain their health. “Some participants believed that their disability predisposed them to illness and that it was important to build resistance against it” (p. 154). The authors themselves suggest that participants were able to reproduce the “goals” of physical education, and interpreted these discourses as positive and meaningful physical education experiences.

While authors of the previously discussed studies do not examine the physical education experiences in terms of discourse, it is apparent that the physical education class is a site within which ableist attitudes and barriers are present. What is yet to be explored is how youth construct the relationship between physical activity, fitness and health, nor do they answer questions concerning how youth make sense of ableist discourses and naturalizing practices perpetuated via the physical education class. In addition to ableist discourses, dominant health discourses are prominent in the physical education classroom. The intersection of these discourses may be extremely oppressive to youth with physical disabilities. As Butler (1998) suggests, “[physical] activity may be seen as healthy, enjoyable and morally good. Abstention from it may be taken as lazy, unhealthy and suggest moral failings about the person who is unwilling to take care of their body.” (p. 92) As demonstrated above, isolation from and lack of participation in the

physical education class is often linked to socio-cultural and attitudinal barriers rather than lack of interest or laziness on the part of the student. Empirical and theoretical research is required to better understand if and how these discourses interact to inform experiences of physical education and understandings of health, fitness and dis/ability.

Conclusions

An overview of the literature examining physical education discourses suggests that healthism and ableism is in fact embedded into school physical education in a multiplicity of ways. These studies point to the uncritical adaptation of popular health and fitness ideology and the ways in which they limit the ability of students to decide for themselves what physical education, physical activity, health and fitness mean. Instead, Kirk and Colquhoun (1990) argue that “a corporeal and individualistic concept of health, in which body shape and fatness play a central role, is being produced through health based education programs” (p. 78). While these studies are convincing, it is important to address the fact that much of the research in this area is reflective of curriculum changes in the 1980s and early 1990s in a very specific area of the world. Further research is required to examine changes in health and physical education discourse that may have resulted from more current changes to the curriculum, the implementation of the curriculum and changes in the attitudes and concerns of teachers and schools who implement the programs. In addition, researchers in this area have focused mainly on physical education programs implemented in Australia and Britain. While they do suggest the adaptation of similar curriculum guidelines and resources in Canada and the United States (Colquhoun, 1991), an examination of the new physical education

curriculum in Ontario and the impact of government and private initiatives aimed at physical educators such as the “Jump Rope for Heart” are required.

Finally, as Kirk and Colquhoun (1990) suggest, individuals and groups are continually reconstructing knowledge and meanings. While “[a]dults often control educational discourses within schools[.]. . .pupils are able to resist these discourses.” (Davis & Watson, 2001, p. 681) It is therefore essential that future empirical research be conducted to better understand the ways in which a variety of adolescents understand, restructure, and resist the discourses surrounding health and physical education lessons.

Health and fitness ideology perpetuates the myriad rules based on restriction and control of certain behaviours may actually have a negative or opposing effects on society’s adoption and maintenance of health behaviours. Youth in particular often receive “confusing and inconsistent messages about health, fitness and exercise from various sources such as home, school, and the media” (Harris, 1994, p.146). While they acquire health information from a variety of sources, youth are not assisted in making sense of this information or relating it to their own experiences and realities. Health promotion messages they receive from media, school, government programs, etc., “may conflict with or may even contradict the everyday observations and experiences of young people.” (Harris, 1994, p.149) When conflicting, ambiguous and overwhelming health messages are perpetuated, anxiety and confusion is generated. This may lead to feelings of anxiety or exhaustion rather than willingness to participate in certain behaviours. As such, it is important that researchers and program developers gain a deep understanding of the socio-cultural contexts within which these youth form their identities and their behaviours.

It is important to mention that I am not attempting to construct physical fitness and health practices initiatives as problematic in themselves. Encouraging people to be physically active or be more aware of the risks of certain behaviours such as smoking and unprotected sex is useful. My point is that, it is easy as a society to uncritically accept and support the relationship and connections between health, fitness, exercise and the body. As Pronger stated in examining sites of dominant physical fitness discourses, the ensemble of health and fitness texts “creates a framework for the production of desire.... These texts enframe desire by establishing a *logos*, a hermeneutic circle, that attempts to circumscribe how we understand the body and ultimately how it should live” (2002, p. 123) As such, it is important to critically examine health and fitness discourses, paying particular attention to the motivations behind their development, and the ways in which they may be oppressive to certain groups of people, or ignore socio-cultural factors.

Furthermore, it is essential to acknowledge that discourses of health, fitness and the body are not passively accepted by youth. The current focus on deconstructing oppressive messages wrought out of health and fitness ideology often results in dominant health discourses being examined in a purely negative sense. A commitment to exposing the problematic nature of individualism may overshadow any consideration of the empowering potential of individualism or the role of human agency in resisting oppressive health discourses. Just because youth receive these messages about health and fitness does not mean they construct health, fitness and the body inline with the dominant discourse.

Despite the strong contributions of this body of literature in creating a critical discourse around current health ideology, limitations and gaps are striking. Specifically,

I suggest that empirical research is required to back up and develop these primarily theoretical and descriptive accounts of popular western health ideology. While many of the articles I reviewed successfully deconstructed dominant discourses of health and the body in North America, researchers have yet to examine constructions and understandings of health, fitness and the body with members of various populations. Such studies are required in order to gauge people's understandings, adoption of, interest in, and rejection or resistance to dominant health and fitness discourses.

In addition, although the gendered and classist nature of healthism is frequently examined in more current healthism research (e.g. Howell & Ingham, 2001; White, Young, & Gillett, 1995), an examination of the relationships and intersections between health discourses and age, gender, race, ability, sexuality, and other relations of difference is still required at both a theoretical and empirical research level. Specifically, while steps to include disability into critiques of healthism are emerging, further research is required to pair the deep and highly developed criticisms and understandings of western health ideology and the place of the body within this ideology found within health and sports sociological research with the mature and continually advancing understandings of disability, impairment and the body, present in the field of disability studies.

Finally, future health and fitness research should not only focus on deconstructing health ideology, but should offer alternative health and fitness discourses that may challenge the perpetuation of dominant discourses that reinforce unequal power relations. Illuminating the ways in which different individuals resist or alter dominant health and fitness discourses may provide a basis for reconstructing less-oppressive, broader, and

more inclusive discourses of health, fitness, and the body that could be promoted through various cultural and social institutions.

Adolescents' Constructions of Health, Fitness and the Body

A lack of qualitative research attempting to understand health and fitness from the view point of youth with physical disabilities leads to questions concerning how youth with physical disabilities interact with messages being perpetuated by health and fitness promoters. Researchers have yet to explore how discourses of health, fitness and the body interact with dominant discourses and images of disability and disabled youth, and how these discourses may be resisted, taken-up, transformed, and practiced by youth with mobility impairments. Fortunately, there has been a recent development of studies examining how non-disabled youth construct health. These studies may provide some insight into the questions being addressed in this study.

Harris (1994) was one of the first researchers to use qualitative research methods to examine young people's understandings of health, fitness and exercise. He believed that developing an understanding of young people's way of thinking about these concepts would allow health educators to design better health-related exercise programs. Using focus groups, Harris asked 61 youth (11 to 14 years old) from a mix of urban and rural schools in the United Kingdom to discuss fitness, exercise and health by answering questions such as, "what comes into your mind when you think of the word 'fitness'?" (p. 144). Several interesting findings emerged out of the data. Specifically, Harris found that the participants in his study tended to form ideas about their own health and fitness levels by comparing themselves to their peers. Regularly, participants cited peers who were less

capable than them at certain activities or who participated in more “unhealthy” behaviours than they did.

In addition, Harris found that the youth in his study conflated “health” and “physical health”. Rarely were psychological and social aspects of health discussed. Youth identified a connection between bodily appearance and health. “For example, fat people were readily stereotyped by most of the young people in the study as unhealthy and unfit.” (Harris, 1994, p. 145) Health was most often described in “negative” terms. Participants understood health as avoiding “unhealthy” behaviours such as smoking and eating junk food. Rarely were pleasurable experiences discussed.

A more recent study by Burrows, Wright and Jungersen-Smith (2002) found similar results. Burrows, Wright and Jungersen-Smith critically examined New Zealand students’ constructions of health, fitness and physical activity. As part of the New Zealand National Education Monitoring Project, these researchers tested grade four and grade eight students’ knowledge, attitudes and understandings of health and fitness. Specifically, students completed five verbal and written tasks. Similarly to Harris (1994), Burrows, Wright and Jungersen-Smith found that students had a corporeal notion of health. Specifically, students tended to define health in terms of participation in particular health behaviours; for example, “eating the right food, drinking lots of water, being active”(p. 43). However, alternative understandings of “being healthy” also emerged. Some students understood health as having a good attitude, a happy family life and/or high self-esteem. It is important to note that “alternative” responses were much more prevalent in the grade eight students than the grade four participants. The authors account for this difference in suggesting that different children have different knowledge

resources available to them at different times in their lives. Unlike Harris (1994) who treated the students in his study as a homogenous group with identical experiences and understandings, Burrows, Wright and Jungersen-Smith (2002) argue that different youth, specifically youth of different ages as well as male and female youth construct and enact health and fitness in different ways at different times.

Uncovering the discursive constructions of fitness and exercise among youth and children has been a key endeavor of qualitative researchers examining understandings of health in students. Placek, Griffin, Dodds, Raymond, Tremino and James (2001) suggest that examining constructions of fitness in students is required based on recent changes in North American physical education curriculum. Specifically, physical education curricula are now emphasizing health-related fitness; a natural reaction to the perpetuation of this concept by governments and various health professionals. Placek and her colleagues examined conceptions of fitness in a group grade six students from an urban middle school in the United States. Similarly to Harris (1994), Placek, et al. found that overwhelmingly, students equated fitness with looking good, and looking good with being thin. In fact, students judged their own fitness levels based on the appearance of their bodies. Similarly, and in response to tasks concerning fitness, students in the Burrows, Wright and Jungersen-Smith study (2002) paid considerable attention to weight and body appearance-- much more so than when students discussed their understandings of health. Weight was regularly referred to as an indicator of fitness, and fitness levels were frequently judged by being able to fit into a particular item of clothing, or the size of one's body.

Finally, Harris (1994) and Burrows, Wright and Jungersen-Smith (2002) noted that students did not clearly distinguish between concepts of “health” and “fitness”. Harris noted that differences between “fitness” and “health” were often blurred. Participants associated fitness with maintaining an “ideal” body shape and moderating “unhealthy” habits such as smoking and drinking. Similarly, Burrows, Wright and Jungersen-Smith found that fitness and health were constructed as interchangeable or very closely related concepts.

According to the literature, the theme of exercise is central to youth’s narratives on “fitness” and “health”. For example, Burrows, Wright and Jungersen-Smith found that most students discussed “purposive and deliberate exercise as an indicator of health or as a way of developing or measuring fitness” (2002, p. 44). However, several studies (e.g., Harris, 1994; Placek et al., 2001) found that students could not explain how exercise helps people to become fit or healthy. When asked about the importance of exercise, all participants interviewed by Placek et al. indicated that exercise was good for you and good for health. However, they could not verbalize any specific understandings of how exercise improves health, nor could they identify specific types of fitness. Instead, students believed specific exercises were completed to improve a particular body part (e.g., a cardiovascular activity such as bicycling was understood as improving your legs).

Understanding that young people draw on available discourses when determining the significance of exercise and physical activity to their identities, Lake (2001) attempted to identify some of the dominant discourses rearticulated by youth when discussing exercise. Specifically, Lake used in-depth interviews to explore what exercise meant to 18 students aged 16 to 18 from a college in England. From his data, Lake found

that youth who expressed negative feelings about exercise most often associated exercise with physical discomfort or pain. This finding was similar to Harris who noted “misunderstandings” of exercise in his participants such as the “no pain, no gain” discourse (1994, p. 145).

Lake (2001) also found that students in his study commonly draw on discourses concerned with personal performance or achievement when discussing their orientation toward or away from physical education, exercise and sport. Specifically, students who enjoyed exercise also enjoyed competing and trying their best to win. Other reasons for participation in exercise were reported, but tended to be marginal compared to the discourse of personal achievement. As Harris (1994) and others have noted, it tends to be youth who do well at sport, exercise and physical education who perceive these concepts positively. Lake (2001) argued that students in his study understood exercise in very limited terms. He recommended that sport and exercise policies focus on creating alternative understandings of participation in sport and exercise. Privileging discourses of competition and team-based sports may have particularly negative effects on young women who do not necessarily value or enjoy exercise oriented in these ways.

Most recently, Wright, MacDonald and Groom (2003) examined young people’s constructions of physical activity. What made this study unique was the authors’ attention to the social and cultural contexts in which these youth experienced and constructed physical activity. Specifically, the data was analyzed and discussed with attention to gender, location and class. To do this, researchers took participants from three schools that were very different in terms of location and culture. One group of students came from a co-educational Catholic secondary school that was situated close to the coast.

Students from this school tended to come from middleclass and more affluent homes. The second group of students attended a protestant boys' school located in the suburbs of a large city in Australia. Students from this school tended to be closely affiliated to their church, and their parents tended to be in professional and managerial occupations. Finally, students were recruited from a government school in the western suburbs. Students from this location tended to be from working class households or households where parents were not employed in full-time work. Many of these students were from cultural minority backgrounds in comparison to students from the other two schools.

Analysis of data from 52 semi-structured interviews revealed that location and cultural background were important factors in understandings of physical activity in the lives and identities of youth. For example, physical activity tended to be less of a priority for many of the students in the governments school. Due to lower socioeconomic status of their families, feeding, clothing and schooling were the main concerns. In contrast, organized physical activity and sport was almost required within the culture of the boy's college. The researchers suggested that in fact, "not to do sport was counter both to the culture and the ethos of the school." (Wright, MacDonald & Groom, 2003, p. 24) Parents were strongly encouraged to attend sporting events and encourage their children to play sport. Through this encouragement, parents themselves gained entrance into the school's culture and community. Interestingly, while youth from the government school faced many economic constraints to participation in physical activity including poverty and family commitments, youth from the affluent boys' school faced cultural constraints to making choices about physical activity. Choices were restricted "by the ways in which

certain sports were valued as contributing to the ethos of the school and the schools purpose of producing particular kinds of citizens” (p. 31).

Wright, MacDonald and Groom (2003) also demonstrated the importance of examining constructions and experiences of physical activity through a gendered lens. Specifically, their results exposed the intersection of gender and ethnicity in experiences of physical activity for the girls in the government school. The researchers found that the school itself was key to connecting young women of an ethnic minority background to physical activity experiences offered in the community. “The school not only provided the information service, but perhaps also a sense of propriety and approval in particular where families may have doubts about the appropriateness of activities for their daughters” (p. 29).

It has become obvious through the research efforts of Wright, MacDonald and Groom (2003) that choices about and participation in health behaviours, physical activity and fitness participation are constrained by different socio-cultural and economic factors. Findings from Wright, MacDonald and Groom were indicative of “the importance of ... structural relations in shaping young people’s physical activity.” (p. 31) It has become apparent that the ways in which health, fitness and physical activity impact the lives and identities of different groups of youth is an area of research that needs further examination.

To date, no study has examined how youth with physical disabilities construct notions of health, fitness and physical activity. However, a study by Watson et al. (1996) did uncover information concerning understandings of health and the body from the perspective of a group of adults with physical disabilities. Specifically, Watson et al.

reported on the health beliefs of a group of adults with physical disabilities in Scotland. Watson and his colleagues interviewed 30 men and women aged 18 to 60 with physical impairments. Unlike other groups of adults who tended to construct an overweight person as an “unhealthy” person (see Watson et al., 1996), the participants in this study were aware of how not having a body that conforms to the cultural norm of a “healthy” body often leads to prejudice.

As a result of personal experiences of being stigmatized as perpetually unhealthy, many of the participants had formed an alternative understanding of health— one that does not equate health with the appearance of a particular body shape, size or ability. As one male participant indicated: “Well, I think, I don’t present a conventional image of health. I know that I’m healthy. If I believe that I’m a healthy person even though I look unhealthy then I must have to accept that other people who may look unhealthy may be just as healthy as me.” (Watson et al., 1996, p. 166) From this study, it seems that experiences of oppression based on ability are intimately related to participants’ constructions of health and the body. However, Canadian youth with physical disabilities may draw from, resist and interpret health and disability discourses very differently from adults with physical disabilities living in Scotland. In addition, while Watson et al.’s study was an important step in sociological disability literature on health and fitness, this study lacked an examination of how relations of difference such as gender may complicate understandings of health and the body.

Tighe (2001) has begun to fill a huge gap in health and disability literature by examining how women with physical impairments understand health and disability. This qualitative study paid particular attention how health and disability interacted and were

important elements in women's identities and life stories. Unstructured interviews were conducted with eight white women aged 27 to 67 years. The overall aim of the interviews was to understand how women with visible physical impairments thought about health.

Interestingly, Tighe (2001) found that the women in her study constructed health and disability in very complex ways. All participants tended to adopt discourses of health and disability from both the social and individual/medical models of disability (see chapter three for definitions of these models). In other words, the women in Tighe's study understand health and disability as separate and socially constructed concepts, but at the same time, their impairment is understood as "an unqualified deviation from the normative health standard" (p. 512).

Several participants discussed messages from society indicating that their bodies would never be considered aesthetically "normal". It was apparent that these women were regularly forced to justify their physical differences to people who had engrained discourses of "physical normalcy". In addition, participants in Tighe's study often managed their health identity by "not letting their disabilities get the best of them." (p. 521) For example, "Sandra" was determined to avoid situations where she would be pitied by others as part of staying in "good" health (p. 528).

In accordance with the social model of disability, a central aspect of many of these women's "health identity" consisted of resisting oppressive stereotypes of disability and "communicating the power of difference, rather than pity, to persons without disabilities" (Tighe, 2001, p. 523). Discussions of health often focused around resisting and confronting negative stereotypes of disability. Women in the study told numerous stories regarding the barriers and negative attitudes they encountered daily that affected their

health and well-being. For example, participants discussed inaccessible health care facilities and the difficulty of finding places in their communities where their health and other daily needs could be met. Women in Tighe's study also questioned the rigidity of binary images of people with disabilities participating in physical activity. For example, Heather commented, "I think the societal image is people with disabilities are not that active, or if you're active, you're a super jock. You know what I mean; you're this top-of-the-line Paralympic competitor" (p. 517).

Unlike results from many of the studies on youth's constructions of health and fitness, Tighe (2001) found that many of the women in her study constructed health as both physical and emotional. The author suggested that due to negative societal understandings of disability, many of the women in her study pointed out that they had to work hard at maintaining and building their emotional health as well as their physical health. Maintaining emotional health was understood as something that had to be done for one's well-being, but in addition, emotional health was essential for political reasons, it was a method for changing non-disabled people's perceptions of women with disabilities as dependent and frail.

In conclusion, the women in Tighe's study (2001) constructed complex understandings of health, disability (and the relationship between the two). As Tighe so clearly indicted: "While each woman seemed to consider societal misconstructions of health and disability in her personal definition of health, she used them merely as stepping stones in finding the way to *her own* vision of the 'kingdom of the well'" (2001, p. 528). However, this study provides limited insight regarding how Canadian youth with physical disabilities construction health, fitness and the body in relation to disability. As

Placek et al. (2001) indicate through their research, youth may have very different views of health and fitness than adults.

I also suggest that youth with disabilities may construct disability and health very differently from the women in Tighe's research because, for instance, most of the women in this study had been involved with research concerning disability and were likely exposed to more marginalized but less oppressive discourses of disability and health. Further research is required to examine if and how youth with disabilities are exposed to alternative discourses of disability and impairment, and how these discourses may influence their constructions of health and fitness.

Overall, the research examined in this section affirm that some of the problematic discourses perpetuated by healthism are being taken up by youth, and that some youth may have a narrow understanding of health and fitness as a result of taking up these discourses. However, these studies also show that different youth construct health and fitness in different ways. In some cases dominant discourses are resisted, reinterpreted, and alternative discourses of health, fitness and the body expressed.

Several of the concerns expressed throughout this research is relevant to health and fitness educators and "experts". Specifically, telling youth that exercise is good for youth, and providing information about health risks and health behaviours does not automatically translate into behaviour change (Harris, 1994). Youth may not recognize the personally enjoyment and deeper connection to one's body that participation in "healthful" activities may lead to. Harris (1994) recognizes that youth participate in exercise for social and psychological benefits such as "social contact, achievement and social well-being" (p. 146). Paradoxically, the youth in his study tended not to discuss

health in positive terms, and did not recognize the potential social and psychological benefits of exercise. It is possible that current health and fitness promotion programs do not emphasize the social and emotional benefits of participation in exercise and other behaviours. I suggest that this oversight may be indicative of the idea that health promotion initiatives and programs tend to be based on adult understandings and concerns with health. However, the health and fitness concerns of youth are likely to be very different. For example, Harris (1994) found that “young people tend to live for the present rather than the future. It would seem that few are likely to turn to and stay with exercise because it may reduce their chance of a heart attack later in life.” (p. 148) As such, future health and fitness initiatives must take into consideration the experiences, understandings and particular socio-cultural realities of youth in order to produce programs that youth will relate to, understand and hopefully adhere to.

It became clear throughout this section that little research examining constructions of health and fitness in adolescents actually exists. To date, research has only been conducted in a limited area of the world, and has mainly focused on non-disabled youth. However, it is apparent through these studies (particularly Burrows, Wright and Jungersen-Smith, 2002) that understandings of health and fitness vary in relation to time, geographical location and socio-cultural context. In particular, Tighe (2001) points to the important intersection of constructions of disability with constructions of health in women with physical disabilities. Similarly, Watson et al. (1996) discovered that marginal discourses of health and the body emerged from interviews with adults with physical disabilities. Overall, these studies point to importance of developing new research projects in order to begin answering questions regarding how youth with

physical disabilities relate to dominant health and fitness discourses and the ways in which experiences of disability and bodily difference inform how they construct health and fitness.

CHAPTER III

THEORETICAL FRAMEWORK

Considering the range of impairments under the disability umbrella; considering the different ways in which they impact on individuals and groups over their lifetime; considering the intersection of disability with other axes of inequality; and considering the challenge which impairment issues to notions of embodiment, we believe it could be argued that disability is the ultimate postmodern concept (Corker & Shakespeare, 2002, p. 15).

Feminist scholars often discuss the need for feminist researchers to treat “gender as one relevant strand among others, also attending to class, ethnicity, age, and sexual orientation.” (Bordo, 1990, p. 139) This belief is in accordance with critiques of mainstream feminism, whose focus on social oppressions and emancipation speak only to the experiences of white, middleclass, heterosexual women (Cassidy, Lord & Mandell, 2001). However, while third wave feminists have begun to focus on issues of race, class and sexual orientation, the experiences of people with disabilities continue to be marginalized. Only recently has disability been conceptualized as a political movement and a social identity (Davis, 2002). In fact, the first wave of “disability studies” (the academic offspring of the disability rights movement) only emerged in the 1970s and 80s (Davis, 2002). Scholars and activists aligned with disability studies have developed an expanding array of insightful work. However, due to the novelty of the disability rights movement and disability studies, there is still a large gap within this area of scholarship

in terms of theoretical development. The purpose of this chapter is to provide a theoretical framework to guide analysis of my research data. However, this chapter also aims to connect postmodern feminist concepts with postmodern concepts from disability studies as both scholarships have much to learn from one another.

Rethinking Impairment: Working Towards a Social Theory of Disability

The “individual” and “social” models of disability (Oliver, 1983) are broad understandings of disability and impairment that were developed by several British disability scholars and activists in reaction to a number of issues and discourses concerning disability and impairment (Oliver, 1996a). The individual model of disability was originally a term used to refer to the medicalization of disability (Oliver, 1996a). However, other models of disability that formed soon after (e.g., the charity model or the medical model) were also influenced by biological determinism and “medically oriented ‘cure and care’ agendas” (Fawcett, 2000, p. 17). As such, the terms “individual model” of disability and “medical model” of disability are often used interchangeably.

According to Davis (2002), the individual or medical model of disability dominated academia in western countries prior to the 1980s. Fawcett (2000) suggests that a medicalized conception of disability remains the dominant discourse of disability. Stone (1995) explains that within this discourse, disability is constructed as a problem residing within the individual and stemming directly from a functional or psychological loss or limitation. This view of disability ignores the possibility that society is built on a narrow view of the “normal” body, and it is this construction that limits certain bodies from full participation.

The social model of disability (Oliver, 1983) is conceptualized in binary to the individual/medical model of disability. The social model of disability distinguishes between “impairment” and “disability” in order to introduce an understanding of disability as a socially constructed form of social oppression (Barnes, Mercer, & Shakespeare, 1999). Within the social model of disability, the term impairment is used to refer to a psychological, physiological or anatomical difference in structure or function of the body (UN, 1983). The term disability is used to refer to the social process, and more specifically the social barriers that turn impairment(s) into a disadvantage (Davis, 2002).

The social model asserts that it is not the individual’s impairment which causes disability . . . or which *is* the disability . . . and it is not the difficulty of individual functioning with physical, sensory or intellectual impairment which generates the problems of disability. Rather, disability is the outcome of social arrangements which work to restrict the activities of people with impairments (Thomas, 1999, p. 14; emphasis in original).

The “problem” of disability is thus displaced from the individual to society. Within the social model [also referred to as the “social construction” of disability (Thomas, 1999)], disability is re-conceptualized as a socially constructed relation of difference similar to that of gender and race.

At first glance, using the social model of disability to understand the ways in which youth with a range of mobility impairments construct “health” and “fitness” is appealing. The social model perpetuates the idea that “people with disabilities” are individuals or groups of people who are oppressed within western society. The social model of disability is a central idea around which people with disabilities organized for political

action (Thomas, 1999). It was important to me that I examine issues surrounding disability and impairment from a position supported by both disability scholars and the disability movement. The fact that the social model of disability developed out of the concerns of people with disabilities was engaging. However, the social model of disability does not account for the growing body of literature indicating that experiences of disability and impairment are gendered, nor does it account for the complex ways in which other relations of difference interact with disability to inform experiences and understandings.

Feminist disability scholars have effectively used feminist analysis to critique the social model of disability as well as to develop new discourses of disability and impairment. Scholars such as Corker (1999a), Corker and French (1999), Fawcett (2000), Marks (1999), and Wendell (1996) challenge disability scholars to incorporate key feminist issues and concepts into the development of disability scholarship, suggesting the necessity of examining issues surrounding disability in ways that are reflexive, appreciative of the importance of personal experience, and sensitive to the interaction of disability with gender and other relations of difference.

At this moment in time, the “dominant materialist social model” (Thomas, 1999, p. 138) does not allow for the development of a social theory of disability that accounts for the complexity of experiences and understandings of disability and impairment. Specifically, Thomas (1999) proposes that feminist disability scholars critique the social model of disability for over-emphasizing social and structural barriers in experiences of disability, while overlooking the role of culture. In addition, by distinguishing between disability and impairment, French and Corker suggest that the social model of disability

has made no room for an analysis of experiences of impairment. “Because impairment is also a referent for the ‘individual’, ‘medical’ and ‘administrative’ models of disability” (1999, p. 3), those adhering to the social model of disability rarely talk about impairment in fear that others will misappropriate the social model and use it to justify inequalities. Finally, Thomas (1999) argues that feminists have critiqued the social model of disability for disregarding the importance of “the personal is political” philosophy. By distinguishing between the personal and the political and the private and the public, “personal and private experiences of disability and impairment are of no real concern or interest in Disability Studies and disability politics.” (Thomas, 1999, p. 139)

A model or understanding of disability that constructs boundaries between “impairment” and “disability” is unsuccessful in acknowledging the ways in which impairment and disability are both socially constructed; there is no “Truth” to the experience of disability or impairment. Research has well documented the complexity of disability (Corker, 1999a; Marks, 1999; Wendell, 1996). Corker notes that “disabled people often allude to a complex existence that occupies the space *between* health and illness, disability and ‘normality’, impairment and empowerment” (1999a, p. 633; emphasis in original). The social model of disability does not explore the complexities of, and interaction between social, biological, and emotional dimensions of experience.

In reaction to feminist critiques of the social model of disability and the need for more theoretical development in the area of disability studies, feminist disability scholars have introduced postmodernist and poststructuralist thought to re-conceptualize disability as a complex *mélange* of biological and social factors and experiences. Using feminist interpretations of concepts developed by theorists such as Jacques Derrida, Michel

Foucault and Maurice Merleau-Ponty has allowed feminist disability scholars to think, research, and write about disability and impairment in a way that is sensitive to the complexity of disability and impairment. A feminist postmodern/poststructural understanding of disability/impairment has also provided me with a framework that accounts for the different ways in which disability affects different people, and is responsive to the different ways that disability and impairment are understood and constructed in different locations and at different historical times. Overall, this framework is useful for exploring how diverse and even contradictory discourses of the health, fitness and the body intersect with, and are informed by disability and other socially constructed relations of difference.

Feminist Postmodernism/s to Explore Disability

Postmodernism is a difficult concept to explain or define based on its far-reaching influence on a number of disciplines and contexts. Academic and otherwise, postmodernism conveys very different meanings within different contexts. As Rail described, “[postmodernism] is an amalgam of often purposely ambiguous and fluid ideas.” (1998, p. x) As such, constructing a theoretical framework that I loosely refer to as a “postmodern feminist exploration of disability” is difficult and even contradictory considering that a main tenet of postmodernism is the rejection of totalizing theories. However, this exercise is useful for the creation of a framework to guide the development of my methodology and to analyze my data.

Postmodernism is a reflection on the current state of western culture and thought (Fawcett, 2000). It brings a loss of certainty in the idea that progress through science and technology will necessarily lead to universal emancipation (Hale, 1996). Postmodernism

problematizes modernity and the culture of Enlightenment that is central to it (Corker & Shakespeare, 2002). Modernity is a term used to describe “the scientific worldview of the Enlightenment.” (Grassie, 1997, p. 84) Through the development of science, “superstitious worldviews” and other “forms of irrationality” were replaced by “[h]uman reason, as exemplified in the deductive thought of mathematics and physics” (Grassie, 1997, p. 84). Modernists view humans as rational, independent subjects, who, through progress and objectivity are on a path to emancipation (Corker & Shakespeare, 2002). Modernists argue that through scientific and technological development, an objective or grand Truth or reality about nature and culture can be uncovered. As such, modernity has come to dominate the university and “social, economic, moral, and cognitive structures [in the western world]” (Grassie, 1997, p. 84).

However, since the mid 1900s, modernity has been heavily critiqued and resisted in a number of ways and within a number of social institutions and structures. In academia, theorists and philosophers from a number of fields are interested in breaking from modernity. Postmodernists promote a view of the social world as inherently complex. In replacement of Enlightenment assumptions of Truth and reality, postmodern thought emphasizes complexity, hybridity, instability, uncertainty, and reflexivity (Corker & Shakespeare, 2002). Postmodern thinkers critique totalizing theories and reject the notion of universals, suggesting that there is not one reality, but many locally and historically specific realities.

Within the context of my research project, poststructuralism as an integral part of postmodern theory. I associate poststructuralist theories (specifically the writings of Derrida and Foucault) with postmodernism, because of their critical view of modernist

concepts and ideas. While there is no unified poststructural theory, poststructural thought is united by a general interest in uncovering and problematizing organizational structures, systems of thought and fixed notions of identity (Evans, Davies, & Wright, in press).

Postmodern feminists understand and define postmodernism in a variety of ways. In addition, many feminists reject postmodernism or find problematic many of its concepts. In accordance with feminist projects, postmodern thought rejects the dominance of grand-narratives and traditional ways of “doing” and “gaining” knowledge. Postmodern thought creates a place for those who are excluded from white, patriarchal and able-bodied ways of knowing and understanding (Rail, 1998). However, McLaren (2002) indicates that some feminists have rejected postmodern theories due to a concern that they undermine the possibility of an emancipatory feminist political project. For instance, McLaren critiques Nancy Harstock for suggesting that doing away with the concept of objective knowledge “results in a relativism that makes any politics for social change untenable” (2002, p. 26). Others have noted that postmodern theories have themselves been developed within structural systems and discourses (e.g., education, linguistics) that reproduce social inequalities, so that they are themselves inherently androcentric (Elliot & Mandell, 1998). Notwithstanding these critiques, its sensitivity to issues of difference and its preference for the marginalized voice (Rail, 1998), postmodernism as a theoretical perspective is useful for studying the experiences of women situated in a variety of marginalized locations and for feminist understandings of disability (Fawcett, 2000). In accordance with Butler (1995), postmodernism can enable agency and political change.

Discourse and Meaning: The Language Game

Feminist postmodern theories are highly concerned with the importance of language because of the relationship of language to meaning, social organization, and power (Weedon, 1997). Following poststructuralism, language is a system of signs where each word is simply the arbitrary pairing of a written or sound image (signifier) and a meaning (signified) (Weedon, 1997). Language constructs social “reality” by structuring meaning rather than reflecting “reality” or the “natural” world, language constitutes meaning (Fawcett, 2000).

According to poststructural theories, language is located within discourse, so that definitions or meanings of words differ from culture to culture, between discourses within a specific culture, and between languages (Weedon, 1997). Meaning is historically and culturally specific. For example, the meaning of the word “feminism” has changed in North America over the last 50 years to mean several different things. In addition, “feminism” has different meanings in different contexts. For example, “feminism” has a very different meaning in my women’s studies class at University compared to how it is used in my parents’ home.

Cole (1998) identifies the writings of Derrida as being particularly concerned with the way in which western thought is centered around an understanding of language as reflecting “reality”. Derrida developed the concept of *différance* to describe the way in which meaning is produced through “the double process of difference and deferral” (Cole, 1998, p. 266). Meaning is deferred because it is “produced temporally, through the trace, and produced through difference” (Cole, 1998, p. 266). Meaning is only developed in its difference from what it is not (Corker & Shakespeare, 2002). According to this

logic, “normal” can only be defined in opposition to “abnormal”. In a sense, “abnormal” is integral to the declaration of “normal”.

Although opposing or “binary” terms depend on one another, Cole posits that language is structured and dependant on categories “that constitute hierarchized binaries” (1998, p. 266). For example, “normal” and “abnormal” are dependent on one another for their own definition. However, within culture, “normal” tends to be privileged or naturalized. “Deconstruction” is the strategy used to expose and interrogate the binary logic and hierarchy upon which language is structured. Postmodern feminist disability scholars have deconstructed the social model of disability to reveal the way in which the “positive’, ‘proud’ and ‘visible’. . . ‘disabled identity’ reinscribes the ‘sick role’ produced through the normal/impaired binary.” (Corker & Shakespeare, 2002, p. 7) More specifically, the social model of disability is based on a dichotomy where biological impairment and socio-structural barriers are constructed as separate and opposite. The construction of this division maintains the individual/medical model of disability because the meaning of one is “necessary for the survival of the other” (Marks, 1999, p. 611).

As previously mentioned, meanings differ within different discourses. The term discourse in a Foucauldian sense; is a term used to describe and identify “regimes of truth” that sustain power relations and construct particular practices through the use of language (Weedon, 1997). Discourses construct boundaries around a particular phenomenon indicating the “reality” or “Truth” of that particular concept. In other words, discourses “are ways of constituting knowledge . . . ways of thinking and constructing meaning” (Weedon, 1997, p. 105).

Discourses may give different meanings to the same situation or concept, and are thus contradictory and in constant competition with one another. For example, discourses perpetuated by the individual model of disability promote a view of the disabled person as unfortunate and as an individual “problem” that results from having a “broken” body or mind. In contrast, social model discourses promote a view of disability as the result of ableism or the result of a society built upon a narrow view of the functional abilities of the human body.

Discourses usually constitute resources that individuals take up to construct meanings and make sense of their “reality” (Evans, Davies, & Wright, in press). As such, postmodern feminist perspectives recognize the important relationship between discourse, knowledge, and power. Since meaning (constructed within discursive practice) constitutes knowledge, it is ultimately linked to power “because particular forms of knowledge are privileged” (Corker, 1999b, p. 193). It is important to understand that discourses are never neutral—they compete in the structuring of society and seek to govern its subjects (Weedon, 1997).

Although the meaning of language is never fixed, some discourses (i.e., those with a lot of social power and influence) are quite effective at temporarily fixing the meaning of terms. Not all discourses have the same social power and influence. Weedon explains that “the most powerful discourses in our society have firm institutional bases, in the law, for example, or in medicine, social welfare, education and in the organization of the family and work” (1997, p. 105). Based on this information, the ways in which dominant discourses define words and concepts can have important consequences. For example, the dominance of rehabilitative understandings of disability has led to an understanding of

disability as “fixable” through hard work and technological advances. As such, people with disabilities become responsible for “overcoming” their impairment so that they may participate fully in society. However, since meaning is never fixed and power is everywhere, dominant discourses are always being contested and resisted. Through deconstruction, interests and values embedded within discourses can be revealed and alternative knowledge perpetuated (Corker & Shakespeare, 2002).

Subjectivity and Identity

As previously argued, discourses are constantly in conflict—battling for authority and prevalence in society. In order for certain discourses to be more dominant than others, they must be taken up by subjects in their construction of the world and of themselves. As Weedon states, “[t]he site of this battle [between discourses] for power is the subjectivity of the individual and it is a battle in which the individual is an active but not sovereign protagonist” (1997, p. 40). As such, an understanding of how adolescents with mobility impairments construct health, fitness and disability can only be realized by determining how they construct subjectivity.

Following Weedon, subjectivity is a term used to refer to the “conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world” (1997, p. 32). However, unlike modernist understandings of subjectivity, postmodernists reject the idea of a rational, autonomous subject. Instead, Foucault suggests that the subject is produced through social and cultural forces. Foucault thereby rejects the idea that there is a core or objective self (McLaren, 2002).

In the context of my thesis, this view of subjectivity is useful for understanding the complexity of ways in which people with disabilities make sense of themselves and the world in which they live. Because subjectivity is “a historically and culturally specific way of conceptualizing the self” (McLaren, 2002, p. 62), one’s understanding of oneself and one’s identity is constantly being changed and renegotiated. For instance, an adolescent with cerebral palsy may refuse to identify herself as disabled in the presence of her non-disabled peers at school due to the stigma attached to people with disabilities, or understand herself as disabled in this setting because of attitudinal and structural barriers. However, when surrounded by her friends with cerebral palsy, she may strongly identify herself as a person with a disability, and even refer to herself as a “gimp”. In this situation, she may not construct herself as disabled because in comparison to her friends with cerebral palsy, she considers her body closer to that of a “non-disabled” person. Foucault’s analysis of subjectivity and critique of “identity categories” allows me to understand the ways in which a person’s identity and subjectivity can be shifting and contradictory depending on her situation and the discourses available to her at that time.

Feminist postmodernists believe that attempting to fix one’s identity (e.g., as a woman or a person with a disability) is problematic. Tying people to their identity can be authoritarian and essentialist. The construction of normative categories assumes a universal “essence” and ignores the multiple and complex differences between members of a particular category (McLaren, 2002). For example, the political concerns of disability activists in North America during the 1970s tended to focus on the concerns of male war veterans with physical disabilities and did not necessarily include the concerns of women with disabilities and/or people with cognitive or sensory impairments. In

addition, in the construction of identity categories, there are always going to be people who are excluded who may identify themselves as part of the group. There are also people who will identify with a particular group in some situations but not in other situations. Consider for example, a woman with ME (myalgic encephalomyelitis or chronic fatigue immune dysfunction disorder) whose pain may be completely overwhelming over some periods of time and almost non-existent at other times. At a political and personal level, I think this is an important point to consider because as Corker and Shakespeare contend, “large numbers of people with impairments . . . identify as neither ‘normal’ nor ‘disabled’, but nevertheless are individually engaged in resisting . . . hegemony” (2002, p. 7).

By understanding identity through Foucault’s concepts of discourse and subjectivity, identity can be understood as constructed, unfixed, and changing. However, McLaren (2002) suggests that some feminist critique Foucault for rejecting identity categories. These feminists argue that without identity categories, collective movement towards emancipation is not possible. As McLaren argues, because identity politics focuses on a particular aspect of identity, e.g., sexual orientation, race, ethnicity, or gender, it de-emphasizes the other aspects of identity.” (2002, p. 119) However, following Butler (1995), identity while unstable and malleable can be politically useful. This is an important way in which we can understand the concept of “people with disabilities” as non-essentialist and beneficial to disability politics. While maintaining the idea that “people with disabilities” as an identity is useful for collective action, we also ensure this identity is not exclusionary nor overshadowing other identities that may be variably important to different people at different times.

Discourse, Technologies of the Body, and Embodiment

I have argued in previous sections that people make sense of their world and understand themselves by drawing on discourses. However, what is still to be examined is how certain discourses are perpetuated, how discourses are taken up, and why certain discourses are more likely to be ascribed to than others. Through an examination of the relationship between discourse, power and the body, I provide an explanation for each of these questions. In addition, this section examines the concept of embodiment in order to connect earlier discussions of subjectivity with issues of the body and power. The concept of embodiment is a useful way to resist binary notions of the body/mind, and better understand complex phenomena such as the relationship of people with mobility and sensory impairments with their mobility devices.

Through the work of Foucault, the notion of knowledge, subjectivity and power are all connected through the concept of discourse. Identifying discourses that people take up in their daily lives may point to the ways in which an individual understands herself, her identity and her world. However, since discourses are temporary, multiple and contradictory, it could be argued that we can never identify the discourses to which an individual has ascribed at a particular point in time. It is important to remember that discourses can be temporarily fixed and must be in circulation in order to be taken up (Weedon, 1997). As such, the discourses to which an individual ascribes are not completely random. Weedon suggests that:

How we live our lives as conscious thinking subjects, and how we give meaning to the material social relations under which we live and which structure our everyday lives, depends on the range and social power of

existing discourses, our access to them and the political strength of the interests in which they represent (1997, p. 26).

Discourses perpetuated by many sources and/or those perpetuated by politically strong institutions such as law, medicine, and education, are more likely to be taken up. Understandably, dominant discourses perpetuated by influential institutions in society often become “hegemonic”—natural or common sense “truths.” However, currently in western society, dominant or hegemonic disability discourses are based on “the concept of normality and the assumption that disabled people want to achieve this normality” (Oliver, 1996b, p. 44). This discourse sets up a “power differential” (Corker, 1999b, p. 195) whereby people without disabilities are legitimized.

As alluded to in the previous quote, power is exercised and comes to influence subjects within discourse (Weedon, 1997). Foucault explains this phenomenon in his discussion of technologies of power. Foucault defines technologies of power as “those technologies which determine the conduct of individuals and submit them to certain ends or domination, an objectivising of the subject” (1997, p. 225). It is through these technologies that power is guided and used to influence individuals. In addition, it is institutions that act as sites for technologies of power (Evans, Davies, & Wright, in press). For example, the rehabilitation centers to which many youth with physical impairments are regularly exposed are a site for technologies of power. Rehabilitation centers utilize disciplinary practices such as measuring and assessing the functionality of bodies, organizing individuals in recreation programs based on type and severity of disability, and prescribing exercises or devices intended to have the individual moving in ways that are more similar to “able-bodied” youth.

Evans, Davies, and Wright (in press) suggest that these technologies of power can work to produce ‘normalizing’, ‘regulating’, classifying’, and ‘surveillance’ effects. Often, individuals take up discourses and ideologies perpetuated by disciplinary practices. According to Evans, Davies and Wright (in press), Foucault uses the term “technologies of the self” to explain the ways individuals take up or subscribe to these practices. However, as Foucault states:

[Technologies of the self] permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality (1988, p. 18).

As such, within the self there is always individuality and the potential for agency and resistance. For example, a wheelchair may be understood as a technology that regulates the way in which a youth with a mobility impairment is able to move (i.e., he or she is “confined” to the wheelchair). However, youth who use wheelchairs often develop ways of moving their chairs (e.g., dancing in/with their chairs to music on a dance floor, doing tricks/stunts where the front of their chairs become airborne) that resist the “restrictions” of their wheelchairs.

Foucault’s technologies of power and technologies of the self point to a way power is exercised through society: Power is exercised through disciplinary practices. On this, Weedon notes that:

[P]ower is shown to take the forms of the surveillance and assessment of individuals, realized in the practices of state institutions, such as prisons,

schools, the army and the workplace. These institutions discipline the body, mind and emotions, constituting them according to the needs of hierarchical forms of power such as gender or class. (1997, pp. 117-118)

By acknowledging that the body is the site of disciplinary practice, we become aware of the importance of the body in the operation of power in society. However, Foucault's conception of the body is very different from modernist understandings. For Foucault, there is no objective experience of the body as the body is highly influenced by discourse. As such, an important site for the operation and implementation of power is the body (McLaren, 2002).

Foucault suggests that the body and subjectivity cannot be separated (McLaren, 2002). The process of "subjectivation"—"the becoming of the subject and the process of subjection", takes place through the body (Butler, 1997, p. 83). The "interiority" of the body is constructed through power relations and through technologies of power over the body. In other words, power operates on the body to produce the psyche, consciousness, and subjectivity (McLaren, 2002). However, according to Butler, "subjection is a kind of power that not only unilaterally *acts on* a given individual as a form of domination, but it also *activates* or forms the subject." (1997, p. 84) As such, "disciplined bodies" can also resist and reconstruct technologies of power. As Fawcett writes, "subjects are not regarded as merely occupying discursive positions, but can be seen as both constructed and capable of construction and critique" (2000, p.111).

The interconnected nature of the body and subjectivity in the work of Foucault and others (e.g., Butler, 1997; McLaren, 2002) present a challenge to dominant discourses of the body that are based on a binary system. Feminist postmodern disability scholars are

interested in developing scholarship that supports an embodied understanding of the disabled/impaired body. Originally, the concept of embodiment came from the phenomenological works of Maurice Merleau-Ponty (Merleau-Ponty, 1962). Similarly to other postmodernists, Merleau-Ponty was interested in transcending dualisms in order to understand phenomena as a whole (see Merleau-Ponty, 1962). Discourses that fragment the body are prevalent in Western society. For example, within Western medicine, the specialization of doctors and researchers has allowed the body to be divided into “artificially manageable” parts (Iwakuma, 2002, p. 77). Feminist postmodern disability scholars have used Merleau-Ponty’s concept of embodiment; arguing that experiences of disability and impairment cannot be fully understood within a binary system (Iwakuma, 2002).

Within disability studies, the idea of embodiment has been used to examine and explain phenomena specific to the experiences of people with disabilities. Specifically, academics are concerned that theories or models based in the mind/body binary are not sufficient to account for the complexity of the experiences of people with disabilities. Instead, they suggest that by perpetuating the historical opposition between the mind and body, “unobservable” phenomena and phenomena representative of the power of mind/body reflexivity will be impossible to study (Iwakuma, 2002). Incorporating this concept of embodiment into my theoretical framework assists me as a non-disabled researcher to understand some of the unique experiences and understandings of adolescents with disabilities. For example, the relationship between a person with a mobility or sensory disability and her mobility or assistive device is extremely difficult for me to understand considering that I do not use this type of aid in my daily life.

Through the concept of embodiment, unobservable phenomenon is still accounted for. Iwakuma explains that people with disabilities often embody their aids, allowing the object to become part of themselves: “If a cane represents a mere object for a person with visual impairments . . . , the skillful use of the cane by the blind would not be possible since a foreign object (a cane) and the body cannot be mingled together. However, in reality this is not the case” (2002, p. 80). Iwakuma writes that the white cane of a person with a visual impairment becomes an extension of their arm. Similarly, “when the lover of a person in a wheelchair touches the chair, s/he shivers In a sense, the person *was* touched: the lover touched the wheelchair as an extension of the person” (2002, p. 78; emphasis in original). The interconnection between the body and the device can only be understood through the acknowledgment of the power of the mind/body interaction. Embodiment cannot occur completely without the “mind” constantly holding an image of the body. Binary understandings of the body/mind are therefore insufficient to account for this phenomenon.

In conclusion, tackling my project from the perspective of embodiment allows me to transcend the boundaries of binary understandings of the body as they relate to disability, health and fitness. In addition, the concept of embodiment allows me to better understand participants’ experiences that are ‘unobservable’ or that point to the complexity of interaction between body and subjectivity. Finally, by substituting the concept of embodiment for binary understandings of the body, I support a view of the body as socially constructed.

Concluding Thoughts

The use of postmodern theories and specifically feminist postmodernism will contribute enormously to the development of a social theory of disability and to the development of research projects such as my own that prioritize the interaction of disability and gender to other relations of difference. Unlike grand theories of social phenomena which are inherently ahistorical, exclusive, and generally inadequate to cover the complex experiences of individuals, using Derrida's concept of *différance*, Foucault's concepts of discourse, subjectivity and power, and Merleau-Ponty's understanding of embodiment provide a useful framework for exploring constructions of health and fitness among adolescents with mobility impairments.

To summarize, this feminist postmodern framework views disability and impairment as constructed through discourse. Disability is one potential aspect of subjectivity and identity that is constructed, malleable, performed and maintained temporarily through discursive strategies. Although I tend to use the term impairment to refer more directly to a biological difference (e.g., lower limb amputation), disability and impairment are unstable, deeply complex, and interrelated experiences and constructions that cannot be conceptualized within modernist dichotomies (Thomas & Corker, 2002). As such, I tend to use the concept disability when not referring directly to the biological difference. In addition, I respect the historical and political importance of the term "people with disabilities" in referring directly to the group of people who are oppressed in western societies based on having a significant biological impairment, and as such, have maintained this term.

From the standpoint of postmodern feminism, health and fitness are discursively constructed concepts whose meanings are malleable, complex, and infinitely multiple (despite the fact that dominant western discourses tend to construct them as static). As a result, it was the primary goal of this project to examine how these concepts are defined, how these definitions reinforce, resist or adapt dominant understandings of health, fitness, physical activity and the body, and what effects these definitions have on the health practices of adolescents with mobility impairments.

Youth is understood as a social process (Wyn & White, 1997) throughout which great psychological, physical, mental, and emotional changes occur. The term youth or adolescence is not understood as a universal concept but is instead composed of many local realities and truths. The experiences of youth vary historically and geographically, across social and cultural groups (Wyn & White, 1997). Since there seems to be a tendency for white, middle class, able-bodied experiences of youth to be constructed as the universal experience, it is important that marginalized histories and understandings of adolescents including those of physically disabled adolescents be given precedence.

Finally, following feminist postmodernism/poststructuralism, health and physical education programs, public and private health promotion strategies, as well as the media are social structures and programs that exercise disciplinary power through dominant discourses of health, fitness, the body, and disability. These discourses are problematically based on a binary logic, and while adolescents may not ascribe to these discourses in their constructions of health and fitness nor necessarily behave in ways that are consistent with these discourses, they do have an effect (Corker & Shakespeare, 2002).

In summary, using a feminist postmodern/poststructuralist framework to guide my research project allows me to examine how power is produced, exercised, and repressed in the construction of knowledge about health, fitness and disability. In addition, this framework provides space to examine how youth with disabilities are positioned within these discourses, and how discourses of gender, disability and other relations of difference impact their constructions of health and fitness. Using concepts and ideas generated by prominent postmodern feminist disability scholars such as Marian Corker, Sally French and Tom Shakespeare, I aimed to contribute to the development of postmodern/poststructuralist feminist theories of disability.

CHAPTER IV

METHODOLOGY

It has been suggested that research that includes children with disabilities as informants may be perceived as ‘time-consuming and labour intensive’. . . [A]ccess to children may be seen as difficult. Nevertheless, to exclude children from being informants in research simply because it’s ‘too hard’ is questionable, and suggests that their views are not important and not worthy of our time and energy (Garth & Aroni, 2003, pp. 564-565).

A gap exists within current mainstream feminist scholarship in that the voices and experiences of people with disabilities have remained marginal. As an able-bodied, white, middle class woman who was new to the qualitative research process, I found myself in a perplexing situation. Looking to feminist literature within my academic discipline as a way to inform the methodology of my Master’s project led me to recognize that North American feminists have almost entirely ignored the theories, methodologies, and research practices of disability scholarship. More specifically, feminist researchers and health sociologists have not developed much scholarship on the role of the non-disabled feminist researcher in conducting less oppressive research on people with disabilities.

Within the areas of the sociology of health and physical activity, there is little qualitative research available on the health and physical activity experiences of youth with disabilities. In addition, the research that has been produced incorporates little feminist disability scholarship into its methodology. One purpose of my chosen

methodology was to produce a kind of research that acknowledges the importance of merging methodological elements from both disability and feminist scholarships in an attempt to resist the schism between feminist and disability studies. I am not suggesting here that the experience of disability simply be “added on” to feminist thought. Rather, I am suggesting that the use of a “feminist” methodology is not all that is required to conduct less oppressive research on disability. The present methodology was developed to meet four main objective of disability research: (a) to share the knowledge and experiences of people with disabilities; (b) to raise consciousness about issues of dis/ableism in both able-bodied and disabled populations; (c) to increase solidarity among and between persons with and without disabilities; and (d) to influence practitioners to make changes in their practices in ways that empower people with disabilities (Rioux & Bach, 1994).

The present chapter centers on a methodology sensitive to the beliefs and concerns of both feminist and disability studies. This chapter outlines my research protocol, my multi-instrumental feminist approach to collecting data, and my choice of participants. I describe in detail the instrumentation that was used to gather and record the data, the data collection procedures, the techniques and theories I used to analyze my data, and how I confirmed the trustworthiness of my results.

Research Protocol

The research protocol consisted of an empirical and qualitative research design aimed to explore the discursive constructions of health, fitness and disability among youth with a mobility impairment. A contemporary poststructuralist feminist methodology, which borrowed ideas and techniques from feminist ethnography,

grounded theory, and disability scholarship was used to uncover the discourses that youth drew from in their constructions of health, fitness and disability.

Feminist Ethnographic Ideas

Traditionally, feminist ethnography has been used to understand the experiences of marginalized socio-cultural groups from the point of view of its members. By centering the voices and experiences of the marginalized group, feminist ethnographers attempt to gain a deep understanding of the social context in which their participants experience life (Reinhartz, 1992). While not ethnography, my research incorporated this element of feminist ethnography into its protocol. Specifically, this project had the overall goal of privileging the voices of youth with mobility impairments and gaining an understanding of the context within which they construct health, fitness and disability. By using the voices of my participants as my research data and preparing for data collection through volunteering with the disability community, I was able to meet this goal. Borrowing elements from feminist ethnography is important in producing research on youth with disabilities as previous studies have rarely focused on how youth understand their own experiences and identities. In addition, it was my hope that this approach would complement the aim of disability scholars in promoting the voices and interests people with disabilities (Barnes, Mercer & Shakespeare, 1999).

Blending Data Collection Techniques and Instruments

Disability scholarship supports the use of multiple techniques and instruments in the collection of research data. Using multiple techniques helps to ensure that experiences and understandings of health, fitness and disability that are difficult for youth to describe verbally could still be expressed and utilized in the analysis stage. In addition, it was

essential that I offer multiple data collection instruments to ensure that youth who communicate differently or have difficulty with drawing and/or writing could participate fully in each step of the research process. Single data collection techniques would not have been sensitive enough to the complexity of these adolescents' realities and were unlikely to correspond with the individual needs of the participants. The blended data collection technique I used consisted of three phases: (a) the draw/describe section of the "write, describe and draw schedule"; (b) the individual guided conversation and (c) the write/describe section of the write, describe and draw schedule. A detailed description of these procedures including the goals of each phase is provided in the "Research Instrument" section of this chapter.

Participants

The feminist poststructuralist research methodology focused on the discursive constructions of health, fitness and disability among adolescents with a range of mobility impairments. Specifically, eight youth (five male and three female) were recruited from community recreation programs and camps in the Ottawa area. Leaders in community recreation programs for youth with disabilities acted as "gatekeepers" to my access. The adolescents ranged from 14 to 17 years of age. Among the participants included in the study, three participants indicated having cerebral palsy, two others indicated having spina bifida, one participant identified himself as having spina muscular atrophy, one indicated having acquired a head injury, and one indicated having nerve damage in the lower appendages as a result of having acquired a virus. All participants were currently attending mainstream high school and had recently been participants in one or more recreation programs or camps for youth with disabilities in the region. This purposive

sample allowed for an exploration of the ways in which physical disability and gender impact constructions of health, fitness and disability.

The term “adolescents with a mobility impairment” requires further conceptualization. As discussed in Chapter III, disability and impairment are inseparable concepts. According to poststructuralist feminism, both disability and impairment are culturally, socially, locationally and historically constructed. As such, any proposed definition of “mobility impairment” was likely to exclude some adolescents who considered themselves to have a mobility impairment. Therefore, all youth who considered themselves to have a mobility impairment were eligible for inclusion in this project.

Research Instruments and Techniques

Individual interviews were conducted in the form of a “guided conversation” (Rubin & Rubin, 1995). Questions from the individual interview guide (see Appendix A) were used to prompt conversation, but participants were encouraged to take control over the direction of the conversation. The guided conversation offered me the opportunity to access participants’ thoughts in their own words, and allowed participants the opportunity to be actively involved in constructing data about themselves. The guided conversations lasted between 45 minutes and two hours and took place in a location that was accessible and convenient for the participant. Specifically, data collection took place in one of three locations: the participant’s home, the hospital, or a recreation facility. In addition, one participant was interviewed over the phone.

The interview guide included a broad range of questions concerning experiences and understandings of health, fitness and disability. Specifically, the guided

conversations focused on: (a) how the adolescent experiences health and fitness; (b) what the adolescent thinks health is, and what fitness is; (c) what health “feels” like, and what fitness “feels” like to the adolescent; (d) how the adolescent recognizes a healthy person and an unhealthy person, a fit and an unfit person; (e) what is their perception of their own health and fitness status, and how it compares to their peers; and (f) where they get their ideas about health and fitness from. In order to further understand differences between discursive constructions of health and fitness that are related to specific aspects of disability and/or competing discourses regarding disability and the disabled body, participants were also asked to discuss what disability means to them and how their understandings of health and fitness may differ from those of their non-disabled peers.

The write, describe and draw schedule (see Appendix B) offered participants the opportunity to present their own representations of health and fitness. In supplying paper and writing utensils or a blank cassette tape, each participant was invited to make a drawing of a “healthy” adolescent and a “fit” adolescent, or describe verbally into the tape recorder what these adolescents would look like. This draw/describe section of the write, describe and draw schedule, in which participants were asked to draw or describe a healthy adolescent and a fit adolescent, took place immediately before the guided conversation commenced. This activity was used to “break the tension” at the beginning of the guided conversation, and to prompt discussion throughout the guided conversation. Particular attention was paid to whether or not the participant had drawn or described an adolescent with a physical disability. This information was used in the later stages of the guided conversation to introduce questions about disability and the role of disability in understandings of health and fitness. Following the guided conversation, participants

were invited to complete the write/describe section of the write, describe and draw schedule. Specifically, youth were asked to write or dictate into a tape-recorder two short stories (10-20 lines each): one about a “healthy” adolescent and one about a “fit” adolescent. Participants were also asked to list their top three sources of information on health and fitness.

Recruitment/Consent Procedures

In order to gain access to participants, I contacted various community leaders and representatives, informing them of the purpose of my study, and asking for their support in this effort. At this time, and in accordance with the conditions laid out by the University of Ottawa’s ethical guidelines, I sought written from Program or Facility Directors via the community leaders. Specifically, community leaders were sent an information package that included: (a) a letter of information summarizing the study and asking permission to access the community center (see Appendix C); (b) an official letter of permission to access the community center (see Appendix D); (c) copies of the parental/ guardian and participant consent forms (see Appendixes E & F respectively). Once approved by the appropriate committee and/or the Director, the signed letter of permission to access the center was acquired and forwarded to the University of Ottawa Ethics Committee.

Once permission to access the center was obtained, an informal presentation regarding the nature and purpose of the study was made at the center to groups of adolescents with physical disabilities (see Appendix G). Any adolescent who expressed interest was asked to fill out a recruitment form (see Appendix H). Potential participants were provided with two copies of the parental/guardian consent form (see Appendix E).

Forms were given to parents/guardians to sign and one copy of the signed form was returned to either the interviewer or the community leader.

Participants were identified via the participant recruitment forms. Those potential participants who considered themselves to have a mobility impairment and who met the criteria of the study in terms of age were contacted by phone at a later date, and asked whether they were still interested in volunteering to participate in a semi-structured individual interview and journal writing session lasting approximately an hour to two hours. Eight participants agreed to participate in the study. The time and place of the data collection session was then scheduled and outstanding parent/guardian consent forms were collected before the commencement of the data collection session.

At the actual data collection session, consent was obtained from each participant in several ways. First, I discussed the nature of the study to the adolescent using simple and concise language. Second, I discussed the content of the participant consent form (see Appendix F) highlighting the specific steps in which the participant in being asked to participate. I ensured that the participant was aware that participation in this study is on a volunteer basis and that they are free to withdraw at any time.

After having read and explained all the necessary details, I asked if the participant had any questions regarding what has been explained or written. I then asked the participant to sign two copies of the participant consent form. Both copies were dated and signed by the participant and myself before the session went any further. Once signed, one copy of the participant consent form was given to the participant, and I kept the other consent form for my records. Finally, in order to maintain anonymity, the participant was asked to choose a pseudonym at the commencement of the session. The participant was

also asked to use their pseudonym on the write, describe and draw schedule. Participants were asked not to use “nicknames” or pseudonyms may allow others to identify them (e.g., internet chat line names).

Concurrent Data Collection and Analysis

Data was analyzed as it was collected so that information obtained in earlier conversations informed the remainder of the data collection. This “constant comparative” method involved asking questions related to concepts developed throughout the interview process and verifying statements and relationships between concepts throughout the interviews in an attempt to develop mini-narratives rich in concepts and understandings of the relationships between them (Strauss & Corbin, 1998). The individual guided conversations were tape-recorded and transcribed as soon as possible following the interview session. While there is always a degree of interpretation when transcribing, each tape was transcribed from beginning to end as closely to verbatim as possible. Auditable information such as laughing and pauses were also entered into transcripts. Throughout the interviews I made brief notes identifying emotional reactions and body language displayed throughout the interviews. These interpretive notes were used throughout the transcription process for reasons of comparison. Written and audio texts from the write, describe and draw schedules were also transcribed. All transcriptions and materials were locked in a filing cabinet accessible only to myself and to my thesis supervisor.

Transcriptions and drawings were be analyzed according to the postmodernist/poststructuralist feminist theoretical framework I outlined in Chapter III. The Nvivo software (Qualitative Solution Research, 2002, version 2.0) was used to organize the

transcribed data so that it could be analyzed and reconstructed into mini-narratives or “stories”. Data analysis was based on “close readings” of the data with particular attention being paid to alternative or marginal interpretations of language and meaning (Scheurich, 1997).

Specifically, preliminary data analysis borrowed elements from grounded theory in order to generate “stories” about how young people with mobility impairments construct health, fitness and disability. According to Creswell (1998), grounded theory functions to develop theory from ideas and concepts that are grounded in the data collected throughout the research process. Borrowing from this tradition, preliminary data analysis aimed to uncover common stories in the data. In accordance with poststructuralist feminism which understands the subject as multiply organized and shifting (Rail, 1998), the goal of this analysis was not to develop a grand theory or “Truth”, but to develop a range of “stories” that are representative of the complex, contradictory, and constructed nature of knowledge.

In addition, a contextual analysis of the data was completed in accordance with feminist postmodernism/poststructuralism. Specifically, the stories generated through preliminary analysis were analyzed within the context of discourses. This analysis was based on an understanding of “reality” as constructed and based on linguistic systems and structures. Discourses, or more specifically discursive fields, are “competing ways of giving meaning to the world (Weedon, 1997, p. 34). Discourses are versions of “reality” or “truth” that sustain particular relations of power at particular times and places. Following a Foucauldian inspired understanding of poststructuralism, dominant discourses emerging from the data were deconstructed “in order to discover the way

meaning is constructed and used.” (Rail, 1998, p. xiii) Dominant discourses of health, fitness, gender, and dis/ability emerging from the stories were deconstructed. By analyzing dominant discourses, underlying relations of power that frame how youth with physical disabilities construct health, fitness and dis/ability were revealed. However, as “discourse is the sight where meanings are contested and power relations determined” (Rail, 1998, p. xiii), particular attention was paid to alternative or “counterhegemonic” discourses of health, fitness and dis/ability.

It was my hope that a feminist postmodernist/poststructuralist analysis would allow me to better understand the ways in which the social, political and cultural contexts of my participants’ lives inform their constructions of health, fitness and disability. In addition, this analysis was useful in revealing interactions between discourses of health, fitness, gender and dis/ability, and in establishing sources of these discourses. Finally, this analysis was used to better understand how youth position themselves in relation to dominant health and fitness ideology.

Ensuring Trustworthiness

The trustworthiness of the research results were ensured in a variety of ways. In order to ensure trustworthiness of the transcriptions, participants were sent their guided conversation transcription so that the participant was able to judge the accuracy of the text. At this time, participants were given the opportunity to make changes and/or additions to their transcription. In addition, to improve the dependability of the data, the data from the guided conversations and the data obtained via the write, describe and draw schedules were compared and contrasted. Thirdly, a reflexive journal was maintained within which I made personal comments and reflections during all stages of the research

process. This journal recorded personal insights made during volunteer experiences, comments related to all conversations and interactions with participants, insights from the guided conversation process, and insights made during the stages of transcription and analysis. Finally, to improve the trustworthiness and authenticity of the results once data collection and analysis had been completed, participants were sent summaries of the results and discussion. Participants were invited to offer feedback on the accuracy of the findings.

CHAPTER V

RESEARCHER LOCATIONS

As a researcher and a feminist, I have become increasingly interested in the production of less oppressive research practices. Familiarizing myself with literature concerning the development of feminist research designs made me acutely aware of my privileged position as a researcher and of the biases and assumptions that I bring to all research interactions. However, as I went through a variety of feminist writings on methodology, it became obvious that little has been written about conducting feminist research on people with disabilities. Disability scholar Mike Clear suggests that, “much feminist literature including that on research and methodology have not included disability very well, if at all, and it has taken disabled feminists themselves to place disabled women on the research agenda.” (1999, pp. 436-437).

Literature on the production of less oppressive research practices is a topic of great interest and concern to disability studies scholars (e.g., Clear, 1999; Morris, 1992; Oliver, 1992; Shakespeare, 1996). Much of this literature has been produced in reaction to an acknowledgement of the historical oppression of people with disabilities by researchers. Oliver (1992) suggests that with the development of disability rights and politics, more and more, [d]isabled people have come to see research as a violation of their experience, as irrelevant to their needs and as failing to improve their material circumstances and quality of life.” (Oliver, 1996, p. 141) The disability community and more specifically disability scholars have heavily criticized feminist research despite its tendency to be sensitive to issues of power and representation. Such criticisms have suggested that non-

disabled researchers regularly participate in oppressive or parasitic research in a number of ways (Shakespeare, 1996). Specifically, there is a concern that non-disabled researchers tend to produce research *on* people with disabilities rather than including them in the research process. For example, Oliver (1992) argues that excluding people with disabilities from the research process often leads to inappropriate questioning and general alienation. In addition, producing research on people with disabilities as opposed to with them sends the message that people with disabilities are unable to produce viable research themselves.

Shakespeare (1996) suggests that self appointed “experts” in the disability field often fail to demonstrate a personal allegiance to the advancement of the disability rights movement. These researchers are criticized for building professional careers on the backs of people with disabilities. As such, many disability scholars emphasize “giving back” to the community that is making your study possible. Jenny Morris, a feminist researcher with a disability criticizes non-disabled feminist researchers for participating in the production of research that reinforces the marginalized status of disabled peoples’ experiences and knowledge (Morris, 1993). She suggests that researchers who fail to explore the ways in which their own subjectivity, cultural assumptions, and biases influence their work on disability are complicit in the production of alienated knowledge. By overlooking one’s authoritative status and privileged social location as a non-disabled researcher, one participates in the production of research that objectifies and alienates people with disabilities whose marginalized statuses prevent their own experiences from being understood as definitive. As a non-disabled researcher and thus an outsider to the disability community, I was worried that I would be complicit in the production of

research that marginalizes the voices, constructions and experiences of the youth in my study while privileging my own concerns and goals for the research project.

In order to prepare my methodology and more specifically get ready for conducting interviews, I did two things. First, I familiarized myself with feminist literature concerning the insider/outsider debate. This literature assisted me in negotiating my ability to conduct research concerning disability from the position of an able-bodied scholar and forced me to reflect on my privileged status as a researcher. Second, I spent the summer of 2003 volunteering with two organizations whose goals were to provide recreation and physical activity opportunities for youth with a range of cognitive, sensory and mobility impairments. The impacts of these two practices on my research project are examined in the remainder of this chapter.

Insider/Outsider Considerations

Feminist reinterpretations of the insider/outsider debate have done an excellent job contesting notions of insider and outsider as opposite and quite separate statuses. Feminist ethnographer Nancy Naples suggests that the “insider/outsider distinction masks power differentials and experiential differences between the researcher and the researched.”(2003, p. 49) Instead, outsidership and insidership may be considered non-static, non-fixed, fluid and permeable locations that are both constructed and expressed. Naples (2003) argues that thinking about insider/outsider in this way may help us as researchers to recognize that we are never fully inside the community or outside the community. Instead, our relationship to the community and/or the participants we are studying is constantly being negotiated and renegotiated. Similarly, the insidership of participants within a community is constantly changing. Drawing on commonalities and

differences between me, my participants, and the community I worked with assisted me in negotiating my outsider status, and raised my sensitivity to the complexities of my participants' realities and identities.

I find it useful to think about power between researchers and participants as dynamic. Naples argues that “[m]embers of the groups or communities we research are also active participants in the research process and can play powerful roles in shaping what we come to know about their lives and the communities in which they live and work” (2003, p. 37). For me then, it was not enough to acknowledge my privileges, reflect upon my biases, and understand that I am constructing a version of my participants' reality from the position of a privileged outsider. Instead, I was interested in blurring my position as an outsider to the disability community in order to challenge the separation between researcher and researched.

In reaction to the knowledge I acquired examining methodological issues of both feminist and disability research, I decided to spend the summer of 2003 volunteering with youth with disabilities. In one case, I volunteered with a Canada wide organization that put on an annual Youth Exchange program for adolescents across Canada with a range of disabilities. The purpose of this week long program was to expose youth to a range of physical activities and develop their leadership skills with the goal of them returning to their communities as leaders and advocates for the creation of physical activity and recreational programming for youth with disabilities. Secondly, I volunteered at a child and youth rehabilitation, continuing care, and education center in Toronto. This hospital-based setting catered to youth with a range of physical disabilities and acquired brain injuries. The youth I interacted with had been admitted for respite care during the

summer in order to allow their parents to go on vacation or take some time away from their children. I volunteered in the recreation program that clients would take part in everyday.

Negotiating my "Outsider" Status

Through these experiences, my status as an outsider to the community was renegotiated. What became very clear was that my outsidership was constructed in different ways depending on the nature of the community. For example, I had an extremely positive experience with the leadership program, as the program tended to promote independence and the development of bonds and support systems between the adolescents themselves and between the adolescents and the leaders and volunteers such as myself. What resulted was a comfort level between myself and the adolescents in my leadership group. In this situation, we regularly shared new experiences such as rock climbing and camping and tubing, and exchanged ideas and personal information with one another. In addition, I shared many commonalities with the youth in this program with respect to race, class, education, cultural background, and in the case of the girls, gender. In this setting, commonalities were able to surface. I was not quite an outsider anymore as I had familiarized myself and became quite knowledgeable about their interests and realities. They treated me as a peer and confidant.

In contrast, the strict confidentiality demanded by the rehabilitation and care center was so intense that volunteers were instructed not to discuss anything that could be considered personal with the youth. This included topics such as their family, and their backgrounds or histories. As such, I only learned about the youth if they offered information themselves. It was difficult for youth to offer information about themselves

considering that the volunteers only engaged in very superficial conversations with the youth. Unlike the leadership exchange, volunteers were simply there to assist youth in the planned activity for that session. As a volunteer within this setting, I was constructed as and remained an outsider. Similarities between the youth and myself did not necessarily assist me in contesting my outsider status as there was a lack of intimacy through which commonalities may have surfaced. My role within the center did not entitle me to be trusted to hold information about the youth and bond with them on a more equal power level. As such, I felt unable to negotiate or change my outsider status.

Interestingly, the attitudes of the service providers and volunteers working with the youth were influential in constructing the insider/outsider status of the youth with disabilities within the community. For instance, when the adolescents at the leadership camp were given the opportunity to play sledge hockey, there was such a great emphasis on encouraging the adolescents who use wheelchairs to participate, that other groups of adolescents were overlooked or not encouraged to try out this new sport. Here, specific groups of youth were being constructed as “legitimate” participants while others were overlooked.

Through my volunteer work in the summer of 2003, I became personally aware of the fluidity of outsidership and insidership. I was given the opportunity to renegotiate my place within the community and challenge the separation between myself and the community I am researching. By engaging with my community, a rapport was established where differences and constraints could be acknowledged and commonalities such as our interests in trying new and creative types of physical activity could be drawn upon to help establish a better relationship and deeper understanding. However, considering myself an

insider just because of my personal connection to the disability community would be a denial of my privileged status and the unequal power relationship always existed between my participants and myself. However, it was useful for me to reflect on the idea that outsidership and insidership are constructed, historically and locally specific, fluid, negotiable, complex and even contradictory. As a new researcher, an exploration of these issues was personally and even ethically useful as it has illuminated the complexity of power and power relations between participants and myself.

Re/Examining Theory and Methodology

Volunteering with youth with a range of disabilities gave me insight into the varying “realities” of these adolescents. Specifically, these experiences prompted me to re-examine my methodology, develop areas of my theoretical framework and literature review that I had overlooked, and develop insights concerning data collection and analysis that would not have been formed otherwise.

First, my volunteer experiences made me aware of the diversity of disability. It assisted me in acknowledging my own prejudices and cultural biases about disability and it made me aware of the prejudices that resided within this community of adolescents. An awareness of the diversity of disability became apparent to me in terms of the wide range and differing levels of impairment that exist. In addition, I became attentive to the effects of other social locations, particularly class, on experiences of oppression. For example, many of youth I worked with at the youth leadership exchange came from middle class homes. As such, many of these youth had multiple opportunities to participate in adapted recreation programs and were able to rely on parents for transportation and financial support so that they could interact regularly with peers in social settings. Youth from

lower socioeconomic backgrounds may not have the assistance required to overcome barriers to participation in social activities.

My volunteer experiences with youth with disabilities also made me aware of the prejudices and oppressive discourses of disability that exist within the community itself. For example, the adolescents without cognitive impairments perpetuated problematic discourses of cognitive disability. I observed that many of the adolescents who did not have cognitive disabilities considered themselves superior to adolescents with cognitive disabilities. Regularly, those with physical impairments excluded adolescents with cognitive disabilities from activities during free time, or would only sit with other non-cognitively impaired peers on bus trips. I overheard one group of boys with mobility impairments making fun of a peer with a cognitive disability on the bus. They described him as “retarded”. Within my research study, it was important and interesting to attend to the ways in which certain adolescents with disabilities reinforce negative cultural assumptions about disability in order that they may be viewed as closer to the “norm”.

Theoretical Developments

I went into my volunteer settings with the hope of interacting with a range of adolescents with mobility impairments and developing a familiarity and comfort around assistive devices and aids such as wheelchairs and walkers that would allow me to see past the device and concentrate on the individual. Instead of “seeing past” the aid, I began to conceptualize their aids as something that should not be ignored or looked past, but as an important aspect of their identities and an extension of their bodies. This understanding provided insight and guidance in the development of my theoretical

framework. Specifically, it became useful for me to understand wheelchairs and other devices in terms of embodiment.

Using Merleau-Ponty's concept of embodiment, Iwakuma (2002) suggests that the aid of a person with a physical disability can become an extension of his or her body so that without the wheelchair or walker, his or her identity or wholeness would not be complete. For the youth I interacted with, the tricks and unique ways they moved and used their devices was a source of pride and even status. Many of the youth would compare their rims in terms of how expensive or high quality they were, and some were very particular about customizing their chairs and walkers to meet their own fashion or identity. In addition, it became apparent that in many cases, youth had embodied their wheelchair to be an extension of their body. For example, some of the younger youth who used chairs argued and fought with one another. During these times, they would grab onto one another's chair to restrict the other's movement. These actions were committed with intentions similar to a child giving another child a kick or a little punch. Having your chair hit, pulled or grabbed was received with the same kind of hostility as having your body physically harmed or violated.

Methodological Concerns

The experience I gained through my volunteer work made me aware of the flexibility I need to offer my participants in terms of the methodology of my project. Communication between people with and without certain disabilities can be difficult if the researcher is not willing to learn the language or mode of communication of the participant. In order to establish a mode of communication that works for the participant

and myself, I realized that I would have to provide opportunities to converse with my participants before the “formal” guided conversation takes place.

Secondly, working with adolescents with a variety of physical impairments led me to reconsider the appropriateness of my research instruments. As my thesis was part of a larger project not originally designed to take into account the differing communicative abilities of its participants, I was required to make several changes. For instance, the larger project asks participants to draw and write about their understandings of health and fitness. For adolescents with a mobility impairment, having them write with a pen and paper was not always appropriate. Offering alternatives such as having participants create an audio recording on a tape recorder or having them dictate or type their journal into a computer allows youth with a range of abilities to participate in every aspect of the project.

Through observation and active participation, I found myself a better position to understand the context within which youth with a mobility impairment construct subjectivity and identity. For example, through my volunteer work, I became aware of the potential influence of physiotherapy and rehabilitation on youth’s constructions of health and understandings of physical activity and the body. For many youth with mobility impairments, physical therapy has been or continues to be a regular part of their lives. As such, it was important to not only to attend to literature on the physiotherapy experiences of youth with disabilities, but to attend to discourses of rehabilitation in my data analysis.

Finally, on a practical level, participating in volunteer work allowed me to familiarize myself with gatekeepers to the community of youth with disabilities. It

offered me the opportunity to develop relationships with potential participants and make contacts that assisted me in recruiting participants.

By interacting closely with a number of youth with disabilities, I developed a personal concern for the well-being of this community. I have become personally dedicated to fighting for opportunities for these youth to become more involved in physical activity and recreation programs. Identifying with the personal and political struggles of adolescents with disabilities made me more aware of the diversity of their experiences and realities, and led me to develop a commitment to giving back to the communities that is making this research possible.

Running head: CONSTRUCTIONS OF HEALTH AMONG YOUTH WITH DISABILITIES

“You might laugh . . . but I think I’m pretty much healthy”:

Exploring the discursive constructions of health and fitness

among youth with mobility impairments

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Abstract

Dating back to the 1980s, concern about the health and fitness of North American young people has led to an array of programs targeting the behaviours of youth. Despite the implementation of numerous programs, research on the health of young Canadians is less than encouraging. In examining dominant discourses of health and fitness, research has suggested that current programs do not reflect the realities of many youths' lives. Of concern is the discursive opposition of health and fitness to mainstream and medical representations of disability. This paper focuses on how a group of Canadian youths aged 14 to 17 years with a variety of mobility impairments discursively construct health and fitness. A poststructuralist feminist lens inspired by feminist disability scholarship is used to analyse and interpret youths' narratives. Our results suggest that participants construct health and fitness as primarily corporeal notions. We discuss and conclude that participants' constructions both rearticulate and resist cultural stereotypes of dis/ability.

“You might laugh . . . but I think I’m pretty much healthy”:

Exploring the Discursive Constructions of Health and Fitness

Among Youth with Mobility Impairments

Dating back to the early 1980s, concern about the health and fitness of North American young people has become increasingly prevalent. Since this time, an array of school-based, community and private health programs have emerged, targeting the behaviours of young people and enticing them to take responsibility for their own health and well-being. Currently, dominant health discourses construct health as an individual obligation and a moral responsibility (Kirk & Colquhoun 1989). Simultaneously, dominant discourses on youth construct adolescence as a time of great instability and difficulty (Butler, R. 1998). Popular representations of youth as prone to engagement in risky behaviours (Giroux 1997, 2000) have led health promotion programs targeting young people to focus on risk management and behaviour modification. Based on an understanding of adolescence as a period of great biological, emotional, and psychological change where lifestyle patterns are forged (Vingilis, Wade & Seeley 2002), “health promotion” and “health prevention” programs aimed at youth have focused on decreasing unhealthy behaviours such as smoking, alcohol and drug use, and unprotected sex, and increasing engagement in healthy practices such as physical activity.

Despite the implementation of numerous health and fitness initiatives and programs aimed at improving the health and well-being of North American adolescents, research on the health of young people is less than encouraging. For example, research in Canada suggests that while youth are knowledgeable about health, this knowledge does not

necessarily translate into actual practice (e.g., LeGrand 2002). Evidence also suggests that approximately 20 percent of Canadian youths in grades nine and ten rate their health status as less than good (Health Canada 1999a), and that fitness activities are some of those least enjoyed by Canadian adolescents (Dallaire & Rail 1996). Perhaps this explains why more than half of Canadian teenagers are sedentary (Craig, Cameron, Russell & Beaulieu, 2000) or, not sufficiently active for health promotion (Cameron, Craig, Coles & Cragg 2003). In addition, young men and women of marginalised socio-cultural groups tend to fair less well in terms of fitness and other health behaviours. For example, evidence suggests higher rates of smoking in young Canadian females compared to males (Health Canada 1999a), and an over-representation of Aboriginal and low-income youth in terms of drug and substance use (Health Canada 1999a, 1999b).

In an attempt to account for continuing concerns over the health and fitness behaviours of young people, despite the implementation of numerous health promotion and prevention programs in Canada and internationally, researchers have examined the assumptions underlying contemporary health and fitness programs (e.g., Dallaire & Rail 1996, Fox & Corbin 1987, Kelly 1998). Evidence suggests that these programs are geared toward white, middleclass, able-bodied, mesomorphic boys (Burrows 2000, Wright 1995), and are based on adult understandings of health and fitness. It may be that these programs do not reflect the concerns and realities of many young people.

Researchers have also investigated the dominant health and fitness discourses that seem to underlie most health promotion and prevention programs (e.g., Crawford 1980, Chrysanthou 2002, Howell & Ingham 2001, White, Young & Gillett 1995). In earlier work by Crawford (1980), the twin concepts of “healthism” and “individualism” were

used to refer to the discursive context within which health is constructed as an unproblematic good, as a primarily behavioural project, and as an individual and moral responsibility. Other scholars have similarly noted that healthist discourses overshadow economic and socio-cultural factors that complicate the maintenance of health and well-being (Howell & Ingham 2001, Tighe 2001, White, Young & Gillett 1995).

In deconstructing dominant health and fitness discourses, researchers have found the equation of a specific body shape, size, weight, and ability with healthiness, fitness, morality, naturalness, and desirability (Chrysanthou 2002, Goldstein 1992, Wendell 1996, White, Young & Gillett 1995). Feminist researchers have challenged the conflation of health with the attainment of an “ideal” body, and demonstrated the gendered ways in which young men and women receive and engage with dominant health and fitness discourses and practices (Gilbert & Gilbert 1998, Markula 1998). It is argued that the pressure for women to have a slim/toned body and for men to develop a muscular/toned body can lead paradoxically to unhealthy practices including but not limited to steroid use and anorexia nervosa (Burrows, Wright & Jungersen-Smith 2002, Markula 1998).

Researchers in the area of disability studies have contested the discursive opposition of health and the healthy body to disability and impairment within mainstream and medical representations of disability (Oliver 1996, Stone 1995, Tighe 2001). Tighe argues that the construction of disability as a deviation from health has resulted in persons with disabilities being awarded a “permanent visa to the kingdom of the sick” (2001, p. 511) regardless of how they understand their own health and well-being.

Currently, health, fitness and physical activity research concerning youth with physical disabilities is dominated by biomedicine (Darrah, Magil-Evans & Adkins 2002).

Studies have indicated that youth with physical disabilities are particularly susceptible to secondary health conditions (Rimmer 1999), and rate their health status lower than their able-bodied peers (Boice 1998). The general conclusion is that “adapted” health promotion and prevention programs should be designed to eliminate, reduce or “fix” bodies with disabilities. Stone (1995) argues that the cultural obsession with preventing illness and maintaining fitness is underlined with a discourse of rehabilitation. Within such rehabilitation discourse, bodies are judged against a socially constructed notion of normality (Oliver 1996) and constructed as potentially fixable such that disability is understood as a temporary state (Stone 1995). The rehabilitation discourse is part of dominant discourses of health that promote physical activity as a means to modify, to improve, or to “fix” the body.

Health promotion programs that perpetuate healthism idealise the non-disabled body and promote an understanding of the “ideal” body as attainable through hard work and self-discipline. Bodies that cannot meet this ideal are associated with deviancy, laziness and moral laxity. Consequently, Davis (2002) suggests that there is great pressure for people with disabilities to “overcome” their physical impairment through medical intervention as well as health and fitness practices.

The few qualitative studies that have centred on the experiences of health and physical activity in youth with physical disabilities indicate the dominance of the rehabilitation discourse in youth daily interactions with health professionals. Often translated into aggressive surgeries, physiotherapy, and a heavy focus on walking, the goals of cure and physical acceptability overshadow concerns over the happiness, sociability, independence and comfort of youth with physical disabilities (Baron 1997,

Middleton 1999). These discourses thus reinforce an equation of health and well-being with how “able-bodied” a young person is.

There is a considerable amount of quantitative research examining the health status and behaviours of young Canadians. However, this literature has little to say about youth understandings of health and fitness or about the significance of health and fitness in their lives. Yet, if we are to design intervention programs for a variety of youth, we must first understand how they construct health and fitness. Only recently have qualitative studies explored the discursive constructions of health and fitness among young people in Canada (George & Rail submitted, Kim & Rail submitted) and internationally (Burrows, Wright & Jungersen-Smith 2002, Harris 1994, Placek et al. 2001). Overwhelmingly, these studies indicate that youth understand health in corporeal terms. Health is constructed as something that is done to or with the body. For example, youth tend to define health in terms of participation in health behaviours; for example, being active, eating the right foods, and avoiding junk food (Burrows, Wright & Jungersen-Smith 2002, Harris 1994, Kim & Rail submitted). Evidence also suggests that youth equate health and fitness with physical appearance: health and fitness mean “looking good” that is, having a proper body shape, size, and weight (Burrows, Wright & Jungersen-Smith 2002, George & Rail submitted, Kim & Rail submitted, Placek et al. 2001).

Most recently, researchers in Canada (e.g., George & Rail submitted, Kim & Rail submitted), and Australia (Wright, MacDonald & Groom 2003) have demonstrated that youths understandings of health, fitness, and physical activity are not homogenous, and that youth do not simply reproduce dominant discourses of health, fitness, and physical activity. For example, Wright, MacDonald and Groom (2003) argue that the meaning and

importance of physical activity among Australian students varies in relation to gender, geographic location, socio-cultural identity, and socio-economic status (Wright, MacDonald & Groom 2003).

In Canada, research on the discursive constructions of health and fitness among second generation Korean-Canadian adolescents (Kim & Rail submitted) and young second generation South Asian Canadian women (George & Rail submitted) has shown that culture plays a prominent role in such constructions. For example, while corporeal themes such as “looking good” and “being physically active” were prominent in Korean-Canadian adolescents’ constructions of health, Kim and Rail found that these young peoples’ emphasis on mental health is linked to expectations from traditional Korean culture and pervasive stereotypes related to Asians in general and Koreans, in particular. It has also been noted that ethno-cultural identity plays a role in the health practices of young people. George and Rail (submitted) found that “looking good” was also central to constructions of health among young South Asian Canadian women, and that these young women were surrounded by racist representations of heterosexual female attractiveness. As a result, the young women were using grooming practices (waxing and other forms of hair removal, bleaching and other techniques to obtain a fairer complexion) to empower themselves and alleviate racism. However, some of these “health” practices were, paradoxically, not so healthy.

These latest studies raise questions about the impact of discourses of dis/ability¹ on the constructions of health and fitness among youth with physical disabilities. Thus far, research has not addressed this topic. However, the small amount of qualitative research conducted outside of Canada has examined how adults with physical disabilities

understand health and the “healthy” body. For instance, Watson and colleagues (1996) found that adults with physical disabilities chose not to define health in terms of body shape and indicated that one could not tell if a person is healthy just by looking. Researchers also suggested that adults with physical disabilities pay close attention to their bodies and approach body maintenance and health care rigorously. Tighe (2001) found that women with physical disabilities feel pressure to define their personal health by able-bodied standards and are well aware of popular cultural messages that indicate that their bodies do not meet the “norm” or “ideal” in terms of health. Interestingly, these women spoke about health as something transcending or resisting negative societal understandings of disability. Their health narratives were quite telling about the time and energy women spend resisting pity, about the intolerant attitudes of non-disabled people, the narrow societal images of disability, and the negotiation of barriers to health such as inaccessible health care facilities.

Although the previously mentioned studies suggest that experiences of disability influence understandings of health and the healthy body, it may be that Canadian youth with physical disabilities would construct health differently from their adult counterparts. The present study focuses on this question and aims to better understand how a group of Canadian youths with mobility impairments² discursively constructs health and fitness. The study is designed to privilege the voices and experiences of youth with mobility impairments, and to answer the following questions: (a) how do these youth discursively construct health and fitness; (b) how do they engage with dominant discourses of health and fitness; and (c) how do they negotiate dominant discourses in the context of their own experiences of health, fitness, disability and gender?

Disability and the Poststructuralist Feminist Perspective

In Canada and other western societies, professionals in the health sciences tend to approach disability from a medical and an individual perspective or model (Bricher 2000). According to this model, disability is constructed as a “problem” residing within the individual and stemming directly from a functional or psychological loss or limitation-- it is associated with tragedy and dependency (Oliver 1996). This model subscribes to the individualistic perspective on health and to the idea that health and well-being can be measured based on the body’s deviancy from an established “norm,” and favours “medically oriented ‘cure and care’ agendas” (Fawcett 2000, p. 17) while ignoring the socially constructed nature of disability.

The “social model” of disability is an alternative theoretical stance around which people with disabilities and, more specifically, disability scholars and activists critique dominant (i.e., medical) discourses of disability (Thomas 1999). Within this model, the term “impairment” refers to a functional limitation or difference that affects the body (Crow 1996). The term “disability” refers to a social process that turns impairment into a disadvantage. Thus, the “problem” of disability is displaced from the individual to society (Davis 2002, Thomas 1999). However, critics of the social model argue that it does not account for the complexity of disability and has made little room for experiences of impairment (Corker 1999, eds. French & Corker 1999, Wendell 1996). According to Corker, “disabled people often allude to the complex existence that occupies the space *between* health and illness, disability and ‘normality’, impairment and empowerment” (1999, p. 633). For many people, disability is not only about structural and attitudinal

ableism, it is also about subjective and practical experiences of impairment (Sullivan & Munford 1998).

In our study, we attempt to resolve some of the issues raised in the above models by using a feminist poststructuralist lens to examine disability. Drawing on Judith Butler's (1990, 1993) notions of sexual difference and gender performativity and Susan Wendell's (1996) reflections on disability as difference, we understand able-bodiedness as a regulatory norm or ideal that produces the bodies it governs. Able-bodiedness constitutes a discursive practice or "performance" that is infused with socially constructed standards of "normal" ability. According to Butler, performativity is "not as a singular or deliberate "act," but, rather . . . the reiterative and citational practice by which discourse produces the effects that it names" (1993, p. 2). In other words, able-bodiedness is discursively produced through the habitual performance of ability. The materiality of the able body is constituted through the performance of regulatory norms of ability.

Following this theory, the formation of able-bodiedness requires the simultaneous production of "abjection" (Butler, J. 1993), or that which is excluded from able-bodiedness. According to Siebers, "Abject beings have bodies and desires that cannot be incorporated into social norms" (2001, 739). As such, abjection or the abject body underlines the artificial, proscribed and performative character of able-bodiedness. As such, we understand disability as a discursive practice or performance that is constituted through its exclusion from socially constructed standards of "normal" ability. Impairment then, is also constituted through its abjection from a cultural concept of the "normal" body. It is not just a biological condition upon which disability is artificially imposed, but

it is governed through the reiteration of hegemonic norms and regulatory practices of ability.

The concepts of “construction” and “discourse” are essential to our poststructuralist feminist perspective. We use the term construction to reflect the notion that “reality” is made through language and cultural practices. We understand experience as having no inherent essential meaning. Instead, “[experience] may be given meaning in language through a range of discursive systems of meaning” (Weedon 1997, p. 33). According to Foucault (1973, 1979) discourses are resources that individuals take up to “construct” meanings and subjectivities. Discourses are competing and often contradictory “regimes of truth” that regulate how individuals attribute meaning to themselves, others, and their social world (Foucault 1973). Not all discourses have the same social power and influence. Discourses with firm institutional bases such as medicine, law, and education are more dominant or successful at temporarily fixing meaning of terms than others (Weedon 1997). However, since alternative discourses always exist (but are often hidden), the meaning of social “reality” is continually being contested. In this study, we focus our analysis on how participants construct health and fitness, and on what discourses they draw (dominant, alternative) for these constructions.

Althusser’s (1971) concept of “interpellation” is also key to our poststructuralist feminist perspective in that it connects constructions to discourses and gives a political understanding of such connection. Indeed, interpellation is a process of indoctrination wherein an individual’s subjectivity is constructed through language (Weedon 1997). Althusser suggests that interpellation is the means by which dominant ideology “hails” subjects or transforms individuals into subjects. Interpellation relies on a process of

recognition whereby the individual recognises herself as assuming a particular subject position within a discourse, within ideology, and a process of misrecognition whereby she assumes that she is the creator of the discourses that construct her subjectivity (Weedon 1997).

Finally, our study rests upon an understanding of “identity” as dynamic and multiple (Tsoldis 1993). Identity is never fixed. It is shifting and constantly being renegotiated in relation to the discourses and discursive practices available to individuals as they participate in culture and construct their subjectivity. In this sense, identity involves the notion of agency and “performance”; a re-experiencing of meanings already socially established (Butler, J. 1990, 1997). For example, young people with disabilities may deploy “health practices” such as wheelchair sports as a way to understand and perform dis/ability. It is through our conversations with our participants that we explored how these youth re-articulate discourses or utilise practices of health, fitness, and dis/ability to construct their identities in conformist, inventive, and sometimes subversive ways.

Researcher Locations

As researchers, we are concerned with producing research that objectifies, alienates, or violates the experiences of our participants. As such, it was important for us to reflect upon our biases and acknowledge our privileged position as researchers, adults, and non-disabled women. Worried we would be complicit in marginalising the voices, understandings, and experiences of our participants, it became important to prioritise the voices of our participants at all stages of the research process, and focus on learning as much as we could from them.

For the first author, this process involved volunteering with a number of organisations whose goals are in part to provide recreation and physical activity opportunities to youth and children with various disabilities. Through these experiences, this author developed sensitivity to the diversity and complexity of the realities and identities of these youth. Participating with a variety of youth with disabilities in various adapted physical and recreational activities allowed her access to some of the concerns, interests and experiences of this community of youth. Through observation and active interaction, she found herself in a better position to understand the context within which these youth construct their understandings of health, fitness, and disability. Subsequently, as relationships between the researcher and various youth formed, she developed a personal allegiance to the advancement of opportunities for youth with disabilities to participate in physical activity and recreation, and a commitment to supporting the communities that made our research possible.

Methodological Considerations

Five male and three female participants were recruited from a number of recreation programs associated with a treatment centre for youth with disabilities in Ontario, Canada. The recreation leader at the centre acted as a gatekeeper to accessing potential participants. Youth between ages 14 and 17 years who could communicate verbally were eligible to participate in the study. In keeping with a feminist poststructuralist framework, we understand that any proposed definition of “mobility impairment” is likely to exclude some adolescents who consider themselves to have a mobility impairment. While potential participants had been classified as physically disabled in order to participate in the recreation programs, all youth who considered themselves to have a mobility

impairment were deemed eligible for inclusion in the project. Among the participants included in the study, some participants indicated having cerebral palsy, some indicated having spina bifida, and others indicated impairments that in some way affect mobility or led them to use a wheelchair from time to time. All participants were currently attending mainstream high school and had been participants of one or more recreation programs or camps for youth with disabilities in the region. Youth interested in participating filled out a recruitment form and were later contacted by the first author to further discuss the study. For youth still interested in participating, the first author arranged a time to meet them at a location of their choice.

The study was approved by the University Ethics Committee as well as by the Research Committee of the treatment centre. Signed consent forms were obtained from the participants and their parents or guardians prior to data collection. To ensure privacy and confidentiality, the participants were asked to provide a pseudonym, which is used in the present study.

Data collection took place in one of three locations: the participant's home, the hospital, or a recreation facility. Three different research instruments were used in the study and each session with a participant lasted between one and two hours. First, depending on their level of comfort in terms of writing and drawing, the participant was invited to fill out a write-and-draw schedule or to describe verbally (this way tape recorded) what a healthy young person looks like and what a fit young person looks like. Second, the participant was invited to take part in a tape-recorded individual interview, which was conducted in the form of a "guided conversation" (Rubin & Rubin 1995). The conversation guide included questions concerning how participants understand health and

fitness, where do they get their ideas about health and fitness, and in what health and fitness practices do they participate. The conversation guide also included questions on participants' understanding of disability and on the impact of disability on their health and fitness experiences. Third, the participant was asked to write or describe two short stories: one about a youth who is healthy and the other about a youth who is fit. The participant also indicated the top three sources of their information about health and fitness.

The qualitative data were collected and analysed using a "constant comparative" method (Strauss & Corbin 1998), such that information obtained in earlier conversations informed the remainder of the data collection. The Nvivo software (Qualitative Solution and Research, 2002) was used to organize the transcriptions and drawings so that the data could be content analyzed and reconstructed into mini-narratives. Both the main and marginal themes emerging from the data were then reviewed under a poststructuralist feminist lens, attending specifically to the dominant, alternative, and counter-hegemonic discourses underlying the youths' narratives on health, fitness and disability.

Constructions of Health and Fitness

The main themes emerging from the youths' narratives produce a picture of how they discursively construct health and fitness (see Table 1). Overwhelmingly, health and fitness were constructed in corporeal terms and were either associated to things that are done to and with the body (eating right, being physically active) or to appearance (having a good body shape/weight). Less frequently, participants described health and fitness in non-corporeal terms such as "feeling good and having energy" and "being smart and using one's mind." In the present section, we will focus on the main themes emerging

from the youth narratives about health and fitness, starting with a comment on the similarities between the constructions of health and the constructions of fitness.

Fitness is “like [what] I said for health”

Overall, health and fitness seemed to be similarly constructed in the youths’ narratives. As is the case for the studies by Burrows, Wright and Jungersen-Smith (2002) and Kim and Rail (submitted), themes used in the constructions of health were also central to the discursive constructions of fitness. As can be seen in Table 1, identical themes emerged in the constructions of health and fitness. Despite this similarity, only a few participants used the terms “health” and “fitness” interchangeably or indicated that they were the same. More often, participants described fitness as a subdivision of health or as something that could lead to being healthier. For instance, in the following quote, I-Teen (15 year old male) defines fitness as only one aspect of health:

Fitness is exercising on a regular basis where health to me is, like, well, people say “at least you have your health,” meaning that you’re not sick or anything.

But it doesn’t necessarily mean you are fit either. So fitness sort of branches off [of] health.

A close examination of the youth stories about health and fitness bring us to doubt the extent to which they conflated health and fitness. Firstly, participants constructed fitness as something different from health in that they saw fitness as purposeful and requiring work and effort. Secondly, participants constructed fitness as something that necessitates specialised knowledge. A good example of this is found in the stories written by Letterbee (15 year old male):

One day this guy named Drew Carey, he had a wife named Britney Spears. He taught her how to stay healthy by being active 'cause he learned that being active can sometimes improve your immune system. And she never got sick, which is rare, but she never got sick for two and a half years. She had one of the best immune systems he had ever seen. He was so surprised he even did it to himself. And he also never got sick again for three years. His friends and his family and Brittany Spears' family were both shocked to hear the results of doing what they do and eating the right food, never getting sick for years to come. And, he was very proud of his wife and his progress. And that's my story of a guy and a girl being healthy all the time.

One day there was this guy and his name was David Letterman. . . . And he had a friend; he had a workout coach called Drew Carey. And Drew Carey taught him how to stay fit by working out, giving him the right food and telling him how to workout, how often, when and where the best place to do it. And he became so fit that he never got sick, like only once a year or every year and a half. So, he owes that all to his friend Drew Carey. And David Letterman said that Drew Carey was the best fit coach that he ever had and, like, he never lost weight, he gained it but he didn't get too fat because he was in shape. So, he owes it all to Drew Carey. And that's my story about a guy who stays fit.

Whereas the main themes emerging from the participants' narratives of health and fitness suggested a conflation of health and fitness, it seems as though participants constructed health as something accessible to most people. In contrast, fitness was

constructed as accessible only to those people who have specialised knowledge, time, and access to “the best place to do it.” At the same time, a majority of participants in our study indicated having a great deal of knowledge about fitness and fitness practices. Fitness was seen as something accessible to them because they felt they had the specialised knowledge required for fitness.

Being Physically Active

One of the most significant elements in the youths’ constructions of health and fitness was “being physically active.” Being physically active meant participating in a range of formally organised or unorganised physical activities, exercises, and sports. Within their statements about physical activity, participants emphasised regular participation and attributed positive personal qualities to people who participate in regular physical activity. Some youth established a link between dedication or perseverance and participating in an exercise regimen. Furthermore, some linked “not being physically active” and participating in a range of “unhealthy” or “risky” practices. These links are apparent in the following excerpt as I-Teen compares the characteristics and practices of people who are fit or unfit:

Fit people? Well, they’re strong of course, endurant, perseverant, a lot of times they maintain that ever important exercise routine. . . . [People who are unfit] don’t make much of an effort to exercise. You know? Like if someone is exercising on a constant, on a regular basis, then I would consider them [fit], and they are eating right as well. If they are pigging out and they are exercising then there’s no point, but um, ya, if they’re eating right and they are

exercising on a regular basis then I consider you fit, and, of course, [they] don't smoke and don't do drugs or anything.

References to being active were as common in narratives on health as they were in narratives on fitness. However, the theme of being active was the most prominent theme within narratives on fitness. Several participants indicated that fit individuals have advanced physical ability and skill, or participate in physical activity several times a day. Einstein's (14 year old male) story about a young person who is fit is telling in this regard:

Well, the young person who is fit would wake-up, eat and then go running, go to the gym, workout, and then come back, workout some more and, then, like, just take a break, read, and then go out to the gym again and do that like five or six times, then come back, read, and just go to sleep.

Although Einstein's statement is extreme in terms of illustrating the relationship between fitness and physical ability/activity, it is quite similar to that of other adolescents in its ability to rearticulate a dominant discourse that associates fitness with able-bodiedness. Frequently, elements of this discourse were apparent in the youths' references to walking. Several participants indicated walking as an important health and fitness practice and others constructed health and fitness in terms of walking ability. Phonegirl (14 year old female) was of the opinion that "a healthy person goes for walks a lot." Einstein mentioned that "[to improve fitness], just go out for walks and that stuff." I-Teen used walking ability as a way to measure his previous health status: "Well, up until the time I was three, I couldn't really walk, so I wouldn't really call myself healthy then."

Similarly, Einstein based his current health status on his ability to walk. Consider the following excerpt:

- Morgan: Do you think you are healthy right now?
- Einstein: No, not really.
- Morgan: No? How come?
- Einstein: Um, just because my body is just still—I'm pretty slow. I can't walk as well as when I was younger.

Many youth constructed health and fitness in terms of physical ability but, paradoxically, their narratives also revealed important moments of resistance to dominant discourses that construct a relationship between health/fitness and physical ability. For example, Jim Page (17 year old male) understood fitness in terms of participating in activities appropriate for one's physical capabilities:

Like when I was really, really, really, bad [ill], I learned that every little bit counts so much. Like, you don't have to go to the gym and lift a thousand pounds a million times and be like, "ya, I'm so strong!" Like, no. It's everyone, no matter what, no matter who you [are], everyone is going to be different. Like, just because you lift less weight than someone else doesn't mean they are [in] better shape than you; doesn't mean that they are better at being healthy than you are. It doesn't matter.

Similarly, most participants indicated that having a physical disability or not being able to walk should not be a barrier to being physically active. Comments such as, "if you can use your legs or not, you can just try all the sports you can" (Einstein) and "you can

still be active in wheelchairs” (Sarah, 17 year old female) suggest that for many youth, participating in regular physical activity is not dependent on able-bodiedness.

Getting into the “Good” Foods

The most prevalent theme in the youths’ constructions of health was “eating right.” Eating fruits and vegetables, not eating “junk” food, drinking lots of fluids, and taking vitamins were considered important to being both healthy and fit. Youth associated healthy eating with feeling energetic and improving health. For them, eating healthy foods provided the fuel necessary for one’s body and mind to function well. Conversely, putting “junk” food into one’s body or not maintaining a healthy diet was associated with being tired and slow. These points are apparent in the following excerpt from a conversation with Phonegirl:

Morgan: What qualities do you think a healthy person has?

Phonegirl: Qualities? They would be able to think a lot, stay awake a lot longer.

Morgan: Why do you think they could think a lot longer?

Phonegirl: They, ‘cause they’re healthy and they’re eating properly and if you don’t eat properly then you don’t think, you don’t, your body doesn’t work right and your brain has to work.

Phonegirl’s statement is characteristic of others in that “eating right” narratives were underlined with a mechanistic approach to the body. In order to gain the energy required to maintain proper functioning, it was understood that people must engage in particular eating practices to supply the body with the proper fuel.

Within health narratives, most participants indicated that maintaining a good diet was the responsibility of the individual. In contrast, unhealthiness was seen as the consequence of being lazy or unable to control one's eating habits. As Angel Stone (15 year old female) explained, unhealthy people do not have the self-control required to control their eating practices:

I don't know, I guess they just lose it. [Morgan: What do you mean "they lose it?"] Like, they're tired of, like, I don't know. They just want to eat something that's fattening and they're used to eating that or something. They're like attached to it.

The participants discursively reproduced aspects of a dominant health discourse that promotes the self-monitoring of bodily practices, including eating. While most participants described how their own eating practices included some degree of self-monitoring (e.g., only eating healthy foods, taking vitamins on a daily basis, refraining from eating junk food), several participants questioned the importance of constant restriction. For example, Wheels (16 year old male) spoke about the "need" to consume "unhealthy" foods at times:

[A healthy person is a] person that eats good. But, but we all need, you know, our sugar once in a while, we all need our coffee and stuff like that. [Being unhealthy] means that someone is neglecting their diet; [somebody] that's going off [their diet] and everyday eating McDonald's, everyday of their life.

In considering their own health practices, particularly the enjoyment experienced in consuming "bad" foods, youth emphasised the notion of moderation. Overall, they

indicated that infrequent participation in unhealthy eating practices had little to no effect on their overall health.

Within their narratives about eating right, adolescents rearticulated a dominant discourse that associates health with self-discipline and individual/moral responsibility. At the same time, several youth also indicated that eating right could be difficult given particular social and economic factors. For instance, Phoneygirl was particularly critical of the popular media's role in enticing youth to consume junk food:

They have all those, like, ice cream commercials [laughs]. So it's, like, take the ice cream commercials off and put the healthy commercials on, then it would make more sense. . . . So if they put healthy things on the TV then maybe it would make me eat healthy or healthier. [Morgan: Do you ever see shows or anything on the TV about health?] No, not at all. . . . [Just] tons of ads for junk food.

Among other youth, knowledge about socio-cultural barriers to healthy eating practices was intertwined with understandings of health and fitness as an individual responsibility. For example, Wheels suggested that people who are obese stay that way due to both economic and attitudinal barriers:

[An unfit individual is] somebody that doesn't, you know, care about their body, doesn't care about, you know, their problems with obesity, stuff like that. . . . Like, say, trying to buy all this diet stuff, it's very expensive, it is, and so, when you're trying to [become fit], financially it can be a big problem. . . . So, there is always a financial reason but there is always an initiative reason as well, and caring.

It is clear that Wheels has been exposed to and is able to reproduce a number of messages about health and healthy eating that come from a variety of sources. Other participants also indicated having acquired a wealth of information about eating right from nutritionists, school, their parents, friends, and the media. It was also apparent that this information was not always consistent. For example, Wheels had this to say about the Canadian government's Food Guide to Healthy Eating:

Well, if you go to talk to any doctor about, say, you know, follow the [Food Guide to Healthy Eating], well, if you actually did that, you'd probably gain almost 800 pounds. [Morgan: Laughs]. It's just, that doesn't help. Um, and when they bring out and say, you know: "this food's not safe, this food is, please do this, do that, do this, do that," it gets a lot of people get worried. They get scared and confused on what things are safe, what things are good, what should we be eating, should not, stuff like that.

Wheels points to the dominance of particular sources of information (i.e. medical) over others in explaining that the information about eating practices provided by his doctor is more valid than the information provided by the government through his school. Wheels' narrative also suggests that he is aware of contradictory nature of the information about eating right and of its consequences. However, Wheels does not indicate that *he* is negatively affected by the conflicting information. Similarly to most participants, Wheels expressed confidence in relation to his nutritional knowledge and practices.

Having a "Good" Body

Conversations about health and fitness included frequent references to the physical appearance of the healthy/fit body. For most participants, being healthy or fit meant having a particular body shape and weight and more specifically, not being obese or overweight, having a skinny or thin body, being muscular, and having a strong body. For example, Letterbee associates being fit with having particular physical characteristics:

Morgan: Do you think you are a fit person?

Letterbee: Ya.

Morgan: What makes you say that?

Letterbee: Well, I have muscle, I have proper weight, I have good food.

Most often, participants described a "healthy adolescent" as one that was not overweight or obese, or was thin, but not too skinny. The "fit adolescent" was also described in this way, but youth emphasised that a fit adolescent would be muscular and strong.

Drawings and descriptions of a "fit adolescent" were constructed differently by male and female participants. Specifically, male participants tended to describe this adolescent as having big muscles or being muscular. Although less frequently, female participants also drew or described the fit adolescent as being muscular. Female participants emphasised being thin or losing weight in their descriptions and drawings of fit adolescents. For instance, Angel Stone drew a fit young girl (see Figure 1) and described this adolescent as "thin and muscles," and as having "better clothes." I-Teen drew a large muscle on the arm of his fit adolescent (see Figure 1), and described him as "no drugs to start of with, muscular, taller."

Our participants' gendered descriptions of the fit adolescent can be understood in terms of contemporary notions of (hetero)sexual attractiveness. Female participants in particular were well aware of the privilege afforded to those whose bodies meet contemporary notions of the "ideal" female body. For instance, Angel Stone recognised that the fit girls at her high school have better clothes than she does. However, at times, participants showed great resistance to the dominant discourses of masculinity and femininity underlying popular constructions of health and fitness. They were also aware of the potential consequences of dominant discourses that construct a relationship between health/fitness and (hetero)sexual attractiveness. For example, in the following conversation, Phonegirl is extremely critical of female bodies seen in the popular media:

- Phonegirl: Have you seen, have you seen what is it, Ashley or Mary-Kate? She's. . . One of them is really sick.
- Morgan: Ya. Anorexic? One of them is anorexic?
- Phonegirl: Ya. Bad idea.
- Morgan: Do you see a lot of pictures of girls like that?
- Phonegirl: Oh ya.
- Morgan: Where do you see those kinds of pictures?
- Phonegirl: It's commercials that, like, do bathing suit ads, really weird. I wouldn't want to be that thin.
- Morgan: Do you think that's healthy?
- Phonegirl: No. . . . They look so tiny, they aren't supposed to look that tiny, they're like paper weight [laughs]. . . I think I look fine.

Phonegirl's statement was quite representative of the other female participants who were also critical of the female bodies that are "too skinny." The latter were associated with being sick, ill, or not eating properly. Phonegirl's understanding of her own body as closer to a healthy "ideal" is also typical in that most male and female participants regarded themselves as appearing healthy and fit. Another example of this is offered in Letterbee's description of a fit young person:

- Morgan: Can you describe what a fit young person looks like?
- Letterbee: Well, it's where they do a lot of exercise and they're not overweight, they're not underweight, they're just a perfect fit; they know how to keep their body in perfect shape for them. Like myself, for instance, now that's what I call a fit person. It's where you. . . [you] don't get overweight, you don't get underweight, you're perfect.

The fit look is one that Letterbee felt he was achieving. Instead of appealing to a dominant (ableist) image of fitness as perpetuated via the media and the health and fitness industry, Letterbee suggested an alternative. In acknowledging that the appearance of the healthy/fit adolescent varies, youth showed moments of resistance to the dominant (ableist) discourse that equates health and fitness to a particular physical appearance. Indeed, some youth suggested that you could not tell if someone is healthy or fit just by looking at them. Jim Page, for instance, explained that his experiences of playing wheelchair basketball with people with a variety of body shapes had shown him that one can not always tell if someone is healthy simply by looking at their body:

Morgan: Um, what does a healthy body look like to you, if you had to describe it?

Jim Page: I can't describe it. It's different for everybody. Everybody is healthy in their own way, it doesn't matter what they look like. . . . Like, I know people who are half a person [laughs], only have half a body but they are still in good shape and they are still healthy people. They just look a bit different and I can't put a face on it or put a shape on being healthy.

Despite popular constructions of the disabled body as ill or unhealthy, Jim Page is similar to other participants in his assertion that people with disabilities can be healthy and fit-- health and fitness are not dependent on able-bodiedness. I-Teen's definition of health emphasises that point:

Well, you know what? I think most people would say that, you know, people with disabilities are unhealthy. But I don't, cause you know, it's a way of life for me, you know, so I consider myself healthy even though I can't walk great distances, have lousy balance, etcetera, etcetera, etcetera.

In this quote, I-Teen acknowledges that most people (i.e., able-bodied people) would probably not agree with his definition. I-Teen is well aware of the popular construction of disability as unhealthy and of the effects of this discursive construction. We should note that although I-Teen was well aware of Morgan's experiences with youth with physical disabilities, his next statement suggests that he is still unsure whether Morgan understands that he is healthy: "I look at myself and *you might laugh when I say this* but, I think I'm pretty much healthy."

In constructing their own bodies as healthy and fit, most participants seemed willing to be interpellated by marginal but progressive discourses of disability and impairment available to them through participation in the disability community. However, this interpellation seemed partial or temporary. Despite the fact that all but one of our participants use a wheelchair in their daily lives and/or when participating in different physical activities and sports, only one represented the healthy or fit adolescent using a mobility device in her drawings or descriptions.

Discussion

Participants' stories, drawings and narratives on health and fitness provided an understanding of how youth with mobility impairments construct health and fitness using elements of dominant and alternative discourses about health, fitness and dis/ability. Overall, participants constructed health and fitness in corporeal terms. Youth over-emphasised being active, eating right, and having a good body; a finding similar to that of Burrows, Wright and Jungersen-Smith (2002). In contrast to previous Canadian studies on youth (i.e., George & Rail submitted, Kim & Rail submitted), the theme of "feeling good" was not prominent in constructions of health and fitness among youth with mobility impairments. Elements such as "minimising stress" and "having self-confidence" were present in some narratives, but were secondary to themes concerning the body. This discrepancy may be explained by the fact that youth with mobility impairments indicated having gained specialised information about health and fitness through their regular encounters with a variety of medical professionals including dieticians, family doctors, surgeons, physiotherapists, kinesiologists, occupational therapists, and nurses. In general, such exposure to medical discourses seemed to provide

participants with motivation and confidence in their constructions of health and fitness as primarily corporeal notions. Related to this is the emergence of the notion of individual responsibility for one's health and fitness. Youth associated participation in regular physical activity, healthy eating, and not engaging in poor personal habits (e.g., eating the wrong foods, watching too much television) to the attainment of health and fitness. Health and fitness were constructed as purposeful, mechanistic and, particularly in the case of fitness, effortful. Participants attributed positive qualities to people who regularly take part in health and fitness practices. Conversely, absence of participation in health practices was attributed to laziness and moral laxity.

Taken together, our results show that participants are often rearticulating a healthist discourse. Numerous scholars have criticised such a discourse that construes health and fitness as an individual and moral responsibility (Crawford 1980, Howell & Ingham 2001, White, Young & Gillett 1995). Discourses of individual and moral responsibility reinforce the construction of health and fitness in primarily corporeal terms. These discourses promote self-discipline; encouraging individuals to look inward at their body as a site over which s/he has primary control. However, we are concerned that an emphasis on the individual and the corporeal overshadow socio-cultural and environmental factors that affect health and reinforce the unequal distribution of health-related resources. In addition, while health and fitness practices such as diet and physical activity are important to the health and well-being of young people, healthist discourses proscribe a very narrow view of such practices. These normalising discourses limit ways of understanding and practicing health and fitness that may be more social and pleasurable.

In addition, the construction of health as a moral responsibility leads to the construction of illness as a personal failure in character, thus blaming the individual who fails to maintain health (Colquhoun 1987, Crawford 1980, Kim & Rail submitted). For youth with mobility impairments whose bodies are popularly constructed in opposition to health and morality, this is particularly problematic. It may be that, for them, discursively constructing health and fitness according to “textbook” notions of health and fitness is a strategy to resist stereotypes of disability. It may also be that, for youth, this latter goal is attained through a “performance” of the healthy/fit body (i.e., participating in health and fitness practices as they understand them).

Despite their (probably strategic but nonetheless) healthist performance, participants also noted a number of socio-cultural factors influencing participation in health and fitness practices such as economic cost, access to facilities and programs, and the popular media. While many of our participants are from middle-class homes and have access to programs and facilities for youth with mobility impairments in their urban community, they are quite aware of the financial, social and familial support required to ensure their participation in such programs. It may be that their lack of access to many mainstream programs and facilities has rendered them particularly knowledgeable about the importance of various socio-cultural factors for regular engagement with health and fitness practices compared to non-disabled youth.

Participants overemphasised having a “good” body weight and shape in their constructions of health and fitness. It was apparent that they were rearticulating elements of a dominant health and fitness discourse that equates a particular image of the body with health and fitness. Such discourses may be particularly oppressive to people with

physical disabilities, whose bodies are popularly constructed in opposition to this “ideal.” However, in contrast to research on non-disabled Canadian youth, our participants did not construct health and fitness as “looking good,” nor did they emphasise conventional characteristics of (hetero)sexual attractiveness such as having a “healthy glow” or “looking presentable” in their constructions of health and fitness (George & Rail submitted, Kim & Rail submitted). This difference may be explained by the pervasiveness of mainstream discourses of disability whereby people with disabilities are discursively constructed as “ugly” (Butler 1998) or excluded from dominant representations of sexual attractiveness. It is possible that youth with mobility impairments have not emphasised “looking good” in their constructions of health and fitness because they have internalised such discourses. However, it is also possible that these youth have strategically excluded “looking good” from their narratives on health and fitness as a way to resist discourses of ableism that are perpetuated through the constructed relationship between health/fitness and (hetero)sexual attractiveness.

The adolescents in our study strongly emphasised avoiding obesity or being overweight in their narratives on health and fitness. This finding can be accounted for by the popularity of messages in the media concerning increasing obesity rates in North American adolescents and children. The message constructing a relationship between a particular body weight and health has been critiqued (Campos 2004) but is nevertheless prominent in all North American media. In addition, health promotion literature aimed at people with physical disabilities has focused on the susceptibility of people with disabilities to “secondary health conditions,” particularly obesity or weight problems (e.g., Marge 1994, Rimmer 1999). It is likely that youth with mobility impairments, who

are regularly exposed to this discourse through their interactions with medical professionals, are borrowing from it to construct health and fitness as having a “good” (i.e., not overweight) body.

Overall, the participants’ constructions of health and fitness were not highly gendered. Health and fitness meant similar things to male and female youth with a mobility impairment. References to specific health and fitness practices were not used to discursively perform gender, nor were they important resources in the youths’ constructions of their identities as young men and women. Participants did not indicate participating in health or fitness practices to improve their sexual attractiveness. Instead, male and female participants associated the maintenance of a “good” body with independence, improvement in athletic performance, and improved mobility. This finding is in contrast to that of Kim and Rail (submitted), who found that Korean-Canadian adolescents’ constructions of health and fitness were highly gendered, and that health practices acted as a resource to construct their gender identity.

Some gender differences still emerged from the participants’ narratives. For instance, males saw the fit adolescent as muscular, whereas females emphasised thinness. In general, however, youth did not reproduce the hegemonic discourses of masculinity and femininity. In fact, most participants were very resistant to discourses that associate health and fitness with a specific gendered ideal of heterosexual attractiveness. For example, narratives on the appearance of a “healthy” adolescent revealed that participants considered the skinny bodies of women in the mass media as sick, unhealthy, or eating disordered.

The lack of difference in the construction of health and fitness between male and female youth with mobility impairments could be accounted for in several ways. First, it is likely that the “culture” has played a role in “normalising” constructions and practices of health and fitness. Second, popular discourses and representations of people with physical disabilities clash with dominant discourses of masculinity and femininity. For example, a discourse of hegemonic masculinity that celebrates strength, aggression, and bodily perfection contrasts greatly with the popular stereotype of males with physical disabilities as frail, asexual, passive, and unhealthy. Parallel to this, feminist disability scholars have argued that the intersection of stereotypes surrounding women and people with disabilities as dependent and passive has led to the infantilisation and asexualisation of women with disabilities (Ferri & Gregg 1998, Gill 1997). As a consequence of such representations and stereotypes, youth may not construct health and fitness in correspondence with hegemonic discourses of masculinity and femininity. Instead, the stories told by youth seem to suggest that they use health and fitness practices to perform alternative gender identities that better coincide with their identity as youth with disabilities.

The results of this study suggest that, for the participants with a mobility impairment, constructions and performances of dis/ability are intertwined with constructions and performances of health and fitness. For instance, some participants resisted dominant discourses of health that construct disability in opposition to health and fitness. For others, experiences of disability and the disabled body led them to resist a dominant discourse that constructs a relationship between health/fitness and an “ideal” body shape. Similarly to the findings of Watson and his colleagues (1996), some youth

indicated that health status is difficult to assess solely on the basis of appearance. It is likely that the cultural experiences of this specific group of youth with mobility impairments affect their constructions of health, fitness, and disability. These participants have regular encounters with health professionals as well as they participate in recreation programs, leagues, or camps designed for people with physical disabilities. These various spaces provide youth with opportunities to socialise and engage with the disability community. Through these experiences, youth are exposed to a range of counter-hegemonic discourses of disability that they take up to discursively construct disability, health, and fitness.

Paradoxically, participants with a mobility impairment also rearticulated elements of dominant (i.e., ableist) discourses of health, fitness, and dis/ability. For example, walking was presented by participants as an important health practice. Some participants went so far as to associate their personal health status with the extent to which they could walk. This finding can be accounted for in several ways. For the majority of participants in this study, walking is an appropriate physical activity based on their mobility capabilities: most participants are able to get out of their wheelchairs and walk unassisted or with the assistance of crutches or a walker. It is also probable that participants are appropriating rehabilitation discourses that tend to privilege walking over other forms of physical activity or other ways of being mobile. According to Barron (1997), physiotherapy and other medical treatments often focus heavily on getting children and youth with physical disabilities to walk in order for their bodies to function more similarly to able-bodied youth. Walking tends to be privileged over wheelchair use even when the latter allows youth greater independence. It may be, then, that for youth with

mobility impairments, walking is a disciplinary practice of normalcy that allows them to perform the disabled body is a way similar to the able-bodied ideal.

The results of our study suggest that despite important moments of resistance, participants tend to construct health and fitness in able-bodied terms. For instance, youths' definitions, drawings, and stories of fitness reproduced elements of a dominant discourse that constructs fitness as achievable through strenuous, able-bodied physical activity practices. In addition, drawings of health and fitness rarely included youth with visible physical disabilities, and short stories of health and fitness rarely described healthy or fit youth using mobility devices. It is likely that dominant discourses and representations of health and fitness have played a role in the participants' constructions of health and fitness in able-bodied terms. The absence of positive representations of people with physical disabilities in health/fitness promotion texts and programs or in the popular media likely played a similar role.

Conclusions

In this paper, we focused on understanding how a group of Canadian youth with a mobility impairment discursively construct health and fitness. In general, these youth constructed health and fitness in corporeal terms (i.e., eating right, being physically active and having a good body). Youth drew a relationship between these terms such that eating right and being active were associated with maintaining the proper body weight/shape. The prevalence of corporeal themes was not surprising given their centrality within medical and mainstream messages of health and fitness. It was apparent that youth with a mobility impairment were hailed by the discourse of healthism, which

explains the rearticulation of individualism and at times, ableism, in their constructions of health and fitness.

While being hailed by healthism, youth with a mobility impairment tended not to recruit from the dominant discourse that constructs youth as particularly susceptible to participation in risk behaviours. Although behaviours such as smoking, drug use, consuming alcohol, and having unprotected sex are highly emphasized in health promotion programs and literature aimed at youth, youth with a mobility impairment do not seem particularly concerned with them. As such, it was apparent that youth are not passively taken-up by dominant health and fitness discourses. On the contrary, our analysis suggests that youth selectively appropriate elements of dominant discourse in their constructions of health and fitness. Dominant health and fitness discourses (although healthist) constitute a resource that youth use strategically to resist mainstream stereotypes of disability and perform alternative gender identities. In addition, youth with a mobility impairment showed important moments of resistance to dominant discourses, for instance, in their recognition that people with disabilities can be healthy and fit and can participate in health and fitness practices.

It is encouraging to find that despite the prevalence of discourses that construct health and fitness in opposition to disability, most youth in this study considered themselves to be healthy and fit and indicated regular participation in health and fitness behaviours such as physical activity. Participants in this study indicated that they have the knowledge, motivation and resources to participate in health and fitness practices. However, we suggest that our participant sample is quite distinctive in having such ease of access to community recreation programs and camps.

Overall, our findings point to importance of socio-cultural context in youths' constructions of health and fitness and indicate that prevailing health and fitness discourses can have a diverse impact on individual youth. This study has also highlighted the prominence of ableist discourses in youths' constructions of health and fitness. In order for these constructions to be reconsidered, we suggest that health promotion programs and literature include alternative images and discourses of health, fitness and disability that resist the discursive construction of health and fitness in opposition to disability and impairment. We argue that the voices of youth with a disability need be privileged and that better links with the disability community is required for the development of future promotion and prevention programs aimed at improving the health and well-being of Canadian youth.

¹ We use the typography "dis/ability" to indicate that there is no clear distinction between "ability" and "disability" and to point out the socially constructed nature of disability. We also use this typography to highlight dominant discourses and "performances" of disability that privilege or focus on physical capability.

² For clarity, we used the term "mobility impairment" to distinguish from other forms of physical disability (e.g., sensory impairment).

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Table 1

**Main Themes in the Discursive Constructions of Health and Fitness
Among Youth with Mobility Impairments**

Health is . . .	Frequency	Fitness is . . .	Frequency
Eating right	*****	Being physically active	*****
Eating “good” or “healthy” foods	*****	Exercising, working out, and doing physical activity	*****
Eating fruits and vegetables	****	Playing sports	****
Not eating junk food	***	Walking	**
Drinking fluids	**		
Taking vitamins	*		
Being physically active	*****	Having a good body shape/weight	***
Exercising, working out, and doing physical activity	*****	Not being overweight or obese	**
Playing sports	***	Having a strong body	**
Walking	**	Having a muscular body	**
		Having a thin or skinny body	*
Having a good body shape/weight	****	Eating right	***
Not being overweight or obese	***	Eating “good” or “healthy” foods	***
Having a thin or skinny body	**	Not eating junk food	*
Having a strong body	**	Drinking fluids	*
Having a muscular body	*	Eating fruits and vegetables	*
Feeling good and having energy	***	Feeling good and having energy	**
Being smart and using your mind	**	Being smart and using your mind	*
Not being sick	**	Getting lots of sleep	*
Getting lots of sleep	*	Not being sick	*

Note: ***** = Very frequently mentioned; **** = Frequently mentioned;
 *** = Less frequently mentioned; ** = Fairly infrequently mentioned;
 * = Infrequently mentioned

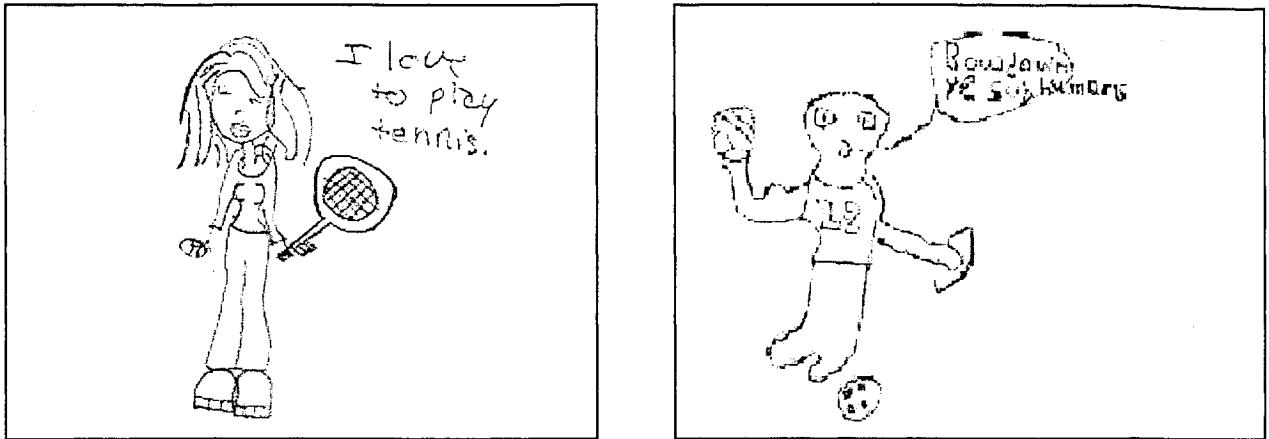


Figure 1. (Left) Angel Stone's drawing of an adolescent who is fit (adolescent to say "I love to play tennis"), and (Right) I-Teen's drawing of an adolescent who is fit (adolescent to say "Bow down ye subhumans").

Running head: CANADIAN YOUTH'S CONSTRUCTIONS OF DISABILITY

“It doesn't mean anything”:

Canadian Youth's Discursive Constructions of Disability

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Abstract

In presenting youth as a homogenous group, research in the social sciences has tended to universalize the experiences of white, middle class, able-bodied adolescents. In North America, few qualitative studies have explored the experiences of youth with disabilities from their own perspective. As such, current research has little to offer in terms of understanding how youth with disabilities are constituted by and actively construct their identities. In this paper, we focus on how Canadian adolescents with a mobility impairment discursively construct disability and negotiate questions of identity. Through an analysis of the transcripts of our conversations with these youth, we argue that they use a variety of discursive strategies to defy oppressive stereotypes, to re/present themselves and (paradoxically) to perform “ability.”

“It doesn’t mean anything”:**Canadian Youth’s Discursive Constructions of Disability**

In many respects, adolescence can be trying for most individuals as they strive for independence (Butler, 1998) and negotiate questions of identity. The North American youth of today grow-up in a world characterized by complexity and marked by intense political struggles, expanding global consumer markets, and emerging technologies. While sociologists have taken a strong interest in issues around adolescence and youth identity, research has traditionally constructed youth as a homogenous group. According to Wyn and White (1997), and Mallan and Pearce (2003), researchers tend to take a “categorical” approach to youth, that is, they define youth primarily in terms of age grouping. We agree that this approach has resulted in an ahistorical construction of youth and the universalization of experiences of white, middle class and able-bodied male adolescents.

More recently, literature has pointed to the fluidity of the notion of “youth” and the differing socio-cultural experiences of youth (e.g., Danesi, 2003; Giroux, 1997; Mallan & Pearce, 2003; Sadowski, 2003; Skelton & Valentine, 1998; Wyn & White, 1997). This literature views youth as a social construction and points to the complexity of contemporary youth identities (Raible & Nieto, 2003). Specifically, scholars concerned with issues surrounding young people with disabilities argue that youth are differentially constructed and actively constitute their own identities within contexts that are not only ableist, but heteronormative and racialized (e.g., Barron, 1997; Wehmeyer, 2003).

Overall, few qualitative studies have explored the experiences and perspectives of youth with disabilities. Instead, most research in the social sciences has focused on the

perspectives of parents, caregivers, teachers, and therapists of youth with disabilities (Garth & Aroni, 2003). While they may provide some insight into the experiences of youth with disabilities, evidence suggests that adults have understandings and experiences of the world that are very different from those of young people, including those with disabilities (Garth & Aroni, 2003; Thomas & O’Kane, 1998). In this regard, Priestley has argued that excluding their voices from research conceals the ways in which youth with disabilities “function as social actors [and negotiate] complex identities within a disabling environment” (1999, p. 93).

Within popular discourse, youth are constructed as incomplete, marginal members of society. According to Giroux (1997) and Brooks (2003), the mass media has demonized and pathologized young people, representing them as both the victims of and a threat to society: dangerous and a danger to themselves. The concept of “youth” has also emerged as a product of consumption (Brooks, 2003; Danesi, 2003). The common association of youth with beauty, strength, hope, vigour, health, and potency has made youth a highly desirable attribute of identity (Hughes, Russell & Paterson, 2005). Fashion, cosmetics and reconstructive technologies now allow those who can afford them to shape and transform their bodies in ways that reflect the appearance of “youth” or “perfection” and hence, youth is now a symbol of being in control of one’s body (Danesi, 2003; Wyn & White, 1997)

In contrast to images of beauty, strength and health, dominant portrayals of youth with disabilities are subject to discourses of tragedy and medicalization (Priestley, 1999). Popular representations and discourses of young people with disabilities tend to be negative. For example, youth with disabilities are often represented as dependent,

vulnerable, passive charity cases through telethon portrayals or pitiable movie and television characters (Davis & Watson, 2002; Priestley, 1999). Hughes, Russell and Paterson (2005) have argued that in an ableist society, disability is constructed as ugly, asexual and frail; therefore, “youth” and “disability” are in tension as identities that are in profound contradiction. However, little is known about how youth with disabilities engage with dominant discourses or what impact these discourses may have on their construction of identity. Currently, literature concerning youth with disabilities tends to be quantitative or theoretical in nature, focusing primarily on the negative impact (e.g., social isolation, segregation, negative self-image) of popular representations and stereotypes of disability on youth identity (Wehmeyer, 2003). As such, the majority of literature has little to offer in terms of understanding how youth with disabilities perform identity or interact with dominant discourses of dis/ability.

In Canada, youth with disabilities make up a significant percentage of the adolescent population. Specifically, there are an estimated 235,380 youth with disabilities ages 10 to 24 residing in Canada (Statistics Canada, 2002). Despite this number, few Canadian studies have focused on the experiences of youth with disabilities (Goodwin & Watkinson, 2000). However, recent qualitative empirical studies conducted in the United Kingdom (e.g., Butler, 1998; Davis, 1998; Davis & Watson, 2001, 2002; Davis, Watson & Cunningham-Burley, 2000; Priestley, 1999) and elsewhere (e.g., Barron, 1997) provide us with some information regarding how youth with disabilities engage with disability discourses.

Davis and Watson (2001, 2002), Priestley (1999), and Barron (1997) have used ethnographic and interview data to explore the lives of young people with a diverse range

of disabilities and socio-cultural experiences. Their results suggest that young people with disabilities encounter a variety of oppressive structures and discourses that act to impose a particular disability identity. In his study, Priestley (1999) demonstrated how participants with physical and sensory disabilities were labeled through a variety of structures and discourses that separate them from other youth (e.g., they are excused or excluded from games at school, they sit with an educational assistant and are separated from other students, they are excused from missing homework assignments). While they suggest that ableist social structures and attitudes inform the identity and influence the experiences of young people with disabilities, these studies also demonstrate that young people with disabilities are not passively shaped by deterministic forces. On the contrary, young people with disabilities display agency and resist agencies imposed on them. For example, Davis and Watson (2002) indicated that their participants showed great resistance to oppressive structures and attitudes through a variety of practices such as verbal communication, body language, and even physical violence. Evidence also suggests that youth with disabilities may at times manipulate dominant discourses of disability or display a “disabled identity” to negotiate ableist structures or gain advantage in particular social contexts (Priestley, 1999). For example, Priestley (1999) has noted that one informant used his “disabled identity” to avoid being reprimanded for being late for class even when his lateness was not the direct result of the accessibility problems at his school.

Working with an older cohort, Barron (1997) examined some of the societal constraints to the establishment of identity among young Swedish women with physical disabilities. Her findings indicate that the experiences of young women with disabilities

are highly inflected by gender. Specifically, while most young women in her study rejected the association of femininity and disability with dependence and passivity, participants tended to over-emphasize a desire to practice traditional female roles such as caring for children and the home. Barron (1997) argued that the internalization and practice of traditional notions of womanhood among her participants was a way in which young women with disabilities could resist being seen as asexual or dependent on the services of others.

Overwhelmingly, empirical qualitative studies on the experiences of young people with disabilities point to the fluidity of experiences of disability and the heterogeneity of young people with disabilities. Concerned with the minimal availability of information concerning the experiences of youth with physical disabilities in a Canadian context, this article focuses on some of the results of a study about the discursive constructions of health and fitness among Canadian youth with a mobility impairment. Youth discursive constructions and practices of health and fitness (see Seeley & Rail, submitted) provided a backdrop for an exploration of the youths' experiences and meanings of dis/ability. In the present paper, we address the following questions: How do Canadian youth with a mobility impairment discursively construct disability? What are the institutional discourses of dis/ability with which these youth interact and how do they influence youths' experiences and identities? How do Canadian youth with a mobility impairment negotiate, appropriate or resist dominant (i.e., ableist) discourses and social structures?

Methodological and Theoretical Considerations

As non-disabled researchers and outsiders to the disability community, we were concerned that our research would be complicit in the production of research that further

marginalizes the voices and experiences of youth with disabilities while privileging our own concerns and goals for the project. For the first author, negotiating her privileged position as an able-bodied researcher and raising her sensitivity to the complexities of the identities and subjectivities of Canadian youth with disabilities took the form of volunteering with a number of organizations whose goals are in part to provide recreation opportunities to youth and children with disabilities. Through observation and interaction, she found herself in a better position to understand the context within which these youth negotiate identity and construct subjectivity. Subsequently, her interaction with these organizations led to a personal commitment to the communities and youth that made our research possible.

We approached this project from a methodological stance inspired by feminist poststructuralism and complemented by methodological practices developed and supported by disability scholars (see Clear, 1999; Rioux & Bach, 1994; Shakepeare, 1996). Our research involved five male and three female youth with a mobility impairment that were between 14 and 17 years of age. Youth were recruited from a number of recreation programs associated with a treatment center for youth with disabilities in Ontario, Canada. In keeping with a feminist poststructuralist framework, we understand that any proposed definition of “mobility impairment” is likely to be exclusionary. While potential participants had been classified as having a disability in order to participate in the recreation programs, youth who considered themselves to have a “mobility impairment” were deemed eligible for inclusion in the project. All participants were currently attending mainstream high school and had been participants of one or more recreation programs or camps for youth with disabilities in the region.

Our analysis is based on individual open-ended interviews that lasted between one and two hours and were held at the participant's home, the hospital, or a recreation facility. Interviews were conducted in the form of a "guided conversation" (Rubin & Rubin, 1995), which was tape-recorded, and later, transcribed. The Nvivo software (Qualitative Solution and Research, 2002) was used to organize the transcriptions so that the data could be content analyzed and reconstructed into mini-narratives. We have used the conversations as sources of information about how youth construct and perform identity and give meaning to their social worlds.

We analyzed and interpreted youths' narratives using a feminist poststructuralist lens. In using feminist poststructuralism, we are appreciative of the importance of subjective and practical experiences of impairment and are sensitive to the complexity and diversity of youth with disabilities. We also suggest that feminist poststructuralism may be useful in resolving some of the discrepancies brought forth through critiques around the social model of disability (Corker, 1999; French & Corker, 1999; Wendell, 1996) and the disability/impairment dichotomy (Sullivan & Munford, 1998).

Drawing on Foucault (1973, 1979) and Weedon (1997), we understand experience as having no inherent or essential meaning. Instead, experience is "constructed" or given meaning through language and cultural practices. Individuals take up discourses to construct meanings and subjectivities. Discourses are competing and often contradictory "regimes of truth" that regulate how individuals attribute meaning to themselves, others, and their social world (Foucault, 1973). Discourses with firm institutional bases such as medicine, law, and education are more dominant or successful at temporarily fixing meaning of terms than others (Weedon, 1997). However, since alternative discourses

always exist (but are often hidden), the meaning of social “reality” is continually being contested.

The concept of identity is key to our poststructuralist feminist framework. Identity is understood as malleable, multiple and dynamic (Tsoldis, 1993). Identity is never fixed, but is constantly being renegotiated in relation to the discourses and discursive practices available to individuals as they participate in culture and construct their subjectivity. In this sense, identity involves the notion of agency and performance; a re-experiencing of meanings already socially established (Butler, 1990, 1997). In this paper, much of our analysis focuses on how Canadian youth with mobility impairments construct identity and on the discourses available to them in their constructions of disability and identity.

Judith Butler’s (1990, 1993) ideas around sexual difference and gender performativity and Susan Wendell’s (1996) reflections on disability as difference inspired our understandings of disability and impairment. Following these theories, we understand disability as one potential aspect of identity that youth may perform. We understand “able-bodiedness” as a regulatory norm or “ideal.” Able-bodiedness constitutes a discursive practice or performance that is infused by socially constructed standards of “normal” ability. According to Butler, performativity is “not as a singular or deliberate “act,” but, rather... the reiterative and citational practice by which discourse produces the effects that it names” (1993, p. 2).

The formation of able-bodiedness requires the simultaneous production of that which is excluded from it. Disability is therefore a discursive practice or performance that is constituted through its exclusion from socially constructed standards of “normal” ability and governed through the reiteration of hegemonic norms and regulatory practices

of ability. While we do not refute experiences of “impairment” in the sense that visceral experiences such as pain and fatigue inflect the experiences of many people with physical disabilities, we do suggest that impairment is not just a static biological fact or condition upon which disability is imposed as it too is governed through the reiteration of hegemonic norms and regulatory practices of ability. In this paper, we use our conversations with participants to explore how youth re-articulate, utilize, resist, and perform both hegemonic and counter-hegemonic norms and practices of dis/ability.

Constructions and Performances of Dis/Ability

Youth with disabilities are regularly exposed to discourses of disability that influence their sense of identity and contribute to their construction of disability (Priestley, 1999). In this study, youths’ narratives on health, fitness and disability were used to create a picture of how participants discursively construct disability and negotiate questions of identity. In using youths’ stories about health and fitness and asking them specific questions about what disability means to them, we came to better understand how participants interact with discourses of dis/ability in their everyday lives.¹

If I Touch Him Will I Get It?

The participants’ narratives on health, fitness and disability suggested that they were frequently exposed to dominant discourses that construct youth with disabilities as pitiable, frail or in need of charity. Participants encountered these discourses via the popular media as well as through their interactions with institutions, peers, teachers, and non-disabled strangers. For example, I-Teen (15 years old, male) spoke about representations of youth with disabilities in the media in this way:

I see very few people, you know, like me [in the media]. For instance, somebody who can walk as I do, you know? Normally, when I see people [in the media] who are disabled, they are in wheelchairs or maybe [have] basic facial deformities. Somebody classifies a disabled person, most people classify a disabled person as being, you know, in a wheelchair, wheelchair-bound. It's a stereotype. [Morgan: Do you ever see images of kids with disabilities on TV or in the media?] Occasionally, you know, the Tiny Tim sort of person. [Morgan: What do you think of that image?] Well, it's like the way ordinary people are portrayed in the media. You'll have, you know, a really, really nice person: it doesn't mean all people are like that. You'll have a really, really, nasty person, a bitter person: it doesn't mean all people are like that. So, you know, it's the same all around.

In the above exchange, I-Teen acknowledges that stereotypical representations of people with disabilities are perpetuated through the popular media. He also suggests that there is a lack of diversity in representations of disability. At the same time, I-Teen does not equate this with ableism, but suggests that overgeneralizations are also made about non-disabled people. I-Teen's tolerant reaction to the negative construction of disability in the media was not unlike the reactions of other participants to experiences of ableism. Most often, dominant (i.e., ableist) discourses were reasoned as being the result of non-disabled people's lack of exposure to people with disabilities. Consider the following excerpt in which Jim Page (17 years old, male) discusses some of the interactions he has had with non-disabled youth at school:

Like, it's good at my school because all the [grade] sevens and eights... We rented the wheelchairs to play basketball and I kind of taught the gym classes how to play, the grade sevens and eights. So, I thought that was really cool. So, all the kids were, like, asking me questions and stuff and they got used to it [my disability] and now they're all, like... Before I did that [taught the gym classes], I noticed when I was in the hall, when I went by them, they would be kind of awkward or like "get out of the way" or would look at me strangely. And ever since I did that, they are just like, "Hey hey, how's it going? Hey, basketball guy." So, I think it's good for able-bodied kids to be exposed to it [disability]. It [the exposure] cures a lot of ignorance. Even, a lot of the time, they seem frightened, like, "crap, if I touch him will I get it? Will he break? Oh my god, I broke him [laughs]."

It is apparent that Jim Page has been exposed to the negative attitudes of his non-disabled peers in his everyday life. His comments are similar to I-Teen's in that he does not display anger or resentment towards the "ignorant" non-disabled youth at his school. For the youth in our study, anger or resentment was not used as a form of resistance. However, it was clear that the youth were not the passive recipients of ableist discourses. For example, Jim Page chose to teach wheelchair basketball to non-disabled youth and was conscious of this action being a way to resist his schoolmates' construction of disability in negative terms. By involving himself in the physical education classes of his non-disabled peers, Jim Page has created a discursive space where marginalized forms of knowledge about disability are prominent.

Gendered Resistance and Negative Disability Identity

According to Weedon, “resistance to the dominant at the level of the individual subject is the first stage in the production of alternative forms of knowledge, or, where such alternatives already exist, of winning individuals over to these discourses and gradually increasing their social power” (1997, pp. 107-108). In our study, participants commonly resisted dominant discourses that impose a particular (i.e., negative) disability identity. In resisting the oppressive attitudes toward disability that result from such discourses, some youth took an important step in re-constituting and circulating alternative discourses of disability. Forms of resistance varied greatly among participants and included reasoning with or educating non-disabled people, acting as an advocate to the disability community, and “performing” physical ability. Other forms of resistance were less explicit and included using humor, interacting primarily with other youth with physical disabilities or refusing to speak to others about disability.

While diverse, the ways in which youth resisted being negatively identified to popular disability discourses tended to be gendered. For example, it was common for male participants to resist negative constructions of disability by proving or “performing” physical ability. For Jim Page, physical activity in general and wheelchair basketball in particular offered an opportunity to display his physical ability and resist stereotypes of disability. Consider the following conversation fragment:

It [my disability] kind of makes me want to be more [physically] active and prove... Uh, ya, it makes me want to prove more that I’m not as much a useless vegetable kind of thing, that I can do things for myself. [Morgan: Do you want to prove that to yourself or to other people?] Mostly to myself. I

couldn't really care less what other people think. It's kind of fun making them, like, "oh my god, did he just do that?" It's fun doing that sometimes but mostly it's just for me. I don't really feel like I have to prove anything to anyone.

The above narrative points to the importance of physical activity as a space within which Jim Page can perform ability, thereby resisting negative constructions of people with disabilities as "useless vegetables" (i.e., worthless and passive). It is interesting that while Jim Page uses physical activity to prove his worth to others, he places greater importance on performing ability as a way to verify his self-worth. This perspective points to the importance of performing disability in ways that resist popular stereotypes, but also to the strength of ableist discourses in youths' negotiations of identity.

Female participants also showed resistance to having imposed on them a negative disability identity. However, they tended to do so by refusing to discuss it with others or showing discomfort in discussing issues around disability. The performance of ability through sport was absent among young women in our sample and other resistance strategies were used. For example, in the following exchange, Phonegirl (15 years old female who uses a wheelchair) tries to avoid the discussion on disability:

Morgan: If people ask you about your disability, what do you usually tell them?

Phonegirl: Ooh, that's a really hard question. Ooh, um, I don't usually, I don't tell them very much because they never ask so that's a really hard question, they never ask.

Morgan: Do you prefer it that way?

- Phonegirl: No, it really doesn't matter, but sometimes it's annoying.
- Morgan: Why is that?
- Phonegirl: Because they keep asking and asking and asking, oi, yoi yoi.
- Morgan: What do you tell them?
- Phonegirl: I say, I already told you, I already told you.
- Morgan: Ok. Um, what does having a disability mean to you?
- Phonegirl: Um, it really doesn't mean anything to me because I don't really care. I just, I just like the way I am, it really doesn't matter.

While Phonegirl suggests that she does not mind discussing disability with others, the exchange points to the discomfort she experiences in discussing issues around disability. This part of the conversation was uncomfortable for her and for Morgan. Eliciting discussion about disability was something we had difficulty doing with our female participants and this contrasted with the male participants. For Phonegirl and others, resisting engagement in conversations about disability or refusing to define themselves as having a disability was a useful strategy to oppose being constructed by others in terms of physical impairment.

Findings on the experiences of youth with disabilities in the United Kingdom (Davis & Watson, 2001, 2002; Priestley, 1999) and other "western" countries (e.g., Barron, 1997, Garth & Aroni, 2003), are similar to ours in that youth with a mobility impairment resisted oppression and the imposition of a negative disability identity in a diversity of ways. In general, these findings support a view of youth with disabilities as complex, fluid, and heterogeneous subjects.

Our results also indicate that the ways in which youth resist are gendered. This may be accounted for by the complex relationship that exists between dominant discourses of disability and hegemonic discourses of masculinity and femininity. Research on masculinities among people with disabilities has emphasized the dissension between dominant discourses of disability and hegemonic discourses of masculinity (Taube, Blinde & Greer, 1999; Valentine, 1999). Specifically, discourses of hegemonic masculinity that celebrate strength, aggression and invulnerability contrast greatly with the popular stereotype of males with a physical disability as frail, asexual, passive and unhealthy. According to findings by Taube, Blinde and Greer (1999) and Valentine (1999), bodily performance in general and team sports in particular were ways in which male participants highlighted or “proved” their physical capabilities. By repeating performative acts of ability, male youth engaged in the construction of an alternative masculine identity that included disability.

In contrast, feminist disability scholars have argued that the intersection of stereotypes surrounding women and people with disabilities as dependent and passive has led to the asexualisation of young women with disabilities (Barron, 1997; Ferri & Gregg 1998; Gill 1997). For females with a mobility impairment, being asked questions related to disability reinforces an asexual identity in that they are being constructed primarily as a person with a disability and not as a young woman. Resisting this imposed identity through physical activity and sport (i.e., performing ability) may not have been a useful strategy for our female participants as such performance would not have been understood as reinforcing hegemonic femininity. We agree with Davis and Watson (2002) that different youth have different resources and capacities to resist ableism at different times

and in different locations. As all but one of our female participants engaged in fitness practices alone or with a close friend, physical activity may not have been considered a useful resource for resistance. Refusing to discuss disability or refusing to consider oneself as being disabled may have been considered better strategies.

What Having a Disability Means

Asking participants specific questions about what disability means to them revealed some of the ways in which youth with a mobility impairment discursively construct disability. Participants' narratives on disability pointed to the influence of dominant discourses of disability on their own negotiations of identity. Frequently, youth constructed disability as a negotiation between barriers or disadvantages and opportunities or advantages. An important part of the youths' narratives was focused on the challenges and barriers they experience as youth with a disability. Simultaneously, youth recognized a number of opportunities or advantages afforded to them based on their "disability status." For example, in the following exchange, Letterbee (15 years old, male) negotiates the advantages and disadvantages of having a disability:

Morgan: When people ask you about your disability what do you usually tell them?

Letterbee: Just a simple answer: that I was born with it, that I have no problem with it, right now anyway. Um, that sometimes you realize it, but you enjoy it sometimes, depends what you are doing, depends what you want to do in your life.

Morgan: What does having a disability mean to you?

- Letterbee: A lot of disadvantages but sometimes it has their own advantages too.
- Morgan: Can you give me some examples of advantages and disadvantages?
- Letterbee: Advantages is you get on the bus for free. . . . Well, if you are taking a bus, don't take it in the winter. . . . The sidewalks get all snowy and you can't push through. Like, it's hard to push through, there is so much snow in the way, you can't get through.

In the previous excerpt, Letterbee constructs having a disability as a compromise between advantages and disadvantages. It is also apparent that Letterbee's experience of advantage (using the bus for free) was dependent on the absence of disabling barriers (an unshoveled sidewalk). This was typical of other participants in that having a disability was frequently constructed as balancing negative experiences characterized by oppression and limitation with experiences of advantage or opportunity. Most youth described their impairment as something with which they are comfortable or as an important part of who they are.

The participants frequently negotiated their identities in relation to non-disabled youth. It was clear that youth's discursive constructions of disability centered on being different from (i.e., "other" than) non-disabled people. For example, consider this excerpt from the conversation with Sarah (17 years old, female):

- Sarah: I just think I don't have a disability; I'm just like other people.

Morgan: Ya. Why do you think that?

Sarah: I don't know, it's just better 'cause, then, they don't think to treat you a different way. Like some people, like my friends, when I tell them "Oh, I have this," they think that I can't do anything so they do everything for me. And I want to do some things cause I know that I can do some things so it's just better to say: "yes I have a disability but, I'm special in my own way and I can do things just like you guys."

In the above exchange, Sarah suggests that she does not think of herself as having a disability because she sees herself as being no different from other (i.e., non-disabled) people. Paradoxically, she tells people that she has a disability and that she sees herself as special. It is apparent that Sarah's negotiation of a disabled identity is complex as she is well aware of dominant constructions of disability. When she rejects thinking of herself as being different from non-disabled youth, she resists having a negative disabled identity imposed on her by others. This strategy was common among other participants.

The finding that youth with a mobility impairment construct disability in relation to non-disabled youth is not surprising considering that traditionally, the identities of people with disabilities have been defined in relation to a socially constructed standard of able-bodiedness. According to Swain and Cameron, "in defining parameters that state emphatically what disabled are *not* (i.e. 'normal'), the dominant cultural discourses determine that disabled people's self-reference is measured against this" (1999, p. 75). Considering that dominant discourses of disability are negative and construct disability as an undesirable attribute, it is not surprising that many youth have difficulty embracing or

even negotiating disability. A common strategy actually used by participants to disassociate themselves from negative stereotypes of disability was to distinguish themselves from other youth with disabilities. Within their health, fitness and disability narratives, it was common for youth to suggest that they are different from other people with disabilities or are not the “typical” person with a disability. This point is apparent in the statements by Wheels (16 years old, male):

Wheels: I’m not your typical person in a wheelchair. I’m not. Why is that? Well, because my grandfather lives with a wheelchair, he had polio and it never stopped him. . . . And I look up to him because he didn’t change his lifestyle because of the disease that he had...

Morgan: You say “I’m not a regular person in a wheelchair,” so, how would you define...

Wheels: The norm? Um, the norm is, um, “Oh, I’m in a wheelchair, I can’t do that”. . . . I have argued with friends in wheelchairs saying “I can’t do that, I can’t do that,” and I say: “you are full of bologna.” Because I can do it, and um, like I said, a lot of people are not leaders, they aren’t. Am I a leader? I don’t know. Do I categorize myself as a leader? I like to think so, cause I like to change a lot of personal, a lot of thoughts, a lot of negativity about people in wheelchairs. Like, one comment was, “oh you are just a bunch of complainers. That is all you do.” I want to change that. . . . I

want to change people's perspective of it [people who use a wheelchair]. And the norm is, you know, "I can't do it, I can't go there," you know, and these excuses.

While committed to challenging stereotypes about people who use wheelchairs, Wheels has separated himself from other youth who use wheelchairs and perpetuate the stereotype that wheelchair users tend to underestimate their abilities or use their disability as an excuse. Like Wheels, who distinguished himself from the "norm," other participants disassociated themselves by suggesting that they were more "able-bodied" than other youth with disabilities, that their impairment was "better" than others or that they fared better than others with a similar impairment:

Morgan: When you hear the word disability, what comes to your mind?

I-Teen: A variety of things, you know? A lot of people would classify disability as what I have, but being disabled is a way of life for me, you know? So, I don't like to classify it so much as a disability, you know? You only have a disability if you think you have a disability.

Morgan: Can you explain a bit more about it being "a way of life"?

I-Teen: Well, I was born with this. I've never known any different, never. I think that would be so much worse than being born with it, you know, being able to walk, run, play sports. . . . [If] I was able-bodied up until now and tomorrow I got into a major car accident and I get my spinal cord trashed, I'm not able to walk, I'm

paralyzed, that would be terrible because I would know what it's like. It's, it's like smelling apple pie and then tasting it and then not being allowed to have it again.

In the above exchange, I-Teen discusses the essentiality of experiences of impairment to his subjectivity. However, while he does not deny impairment, he also does not identify himself as being disabled. I-Teen's statement also suggests that he views himself as more fortunate than, and thus different from other people with mobility impairments. The articulation of ableist discourses by participants such as Wheels and I-Teen is a finding common to recent qualitative studies on youth with disabilities. For example, Davis and Watson (2001, 2002) noted the use of ableist discourses by youth with disabilities as a means of oppressing other disabled youth (Davis & Watson, 2001, 2002). Such findings are also indicative of the power of ableist discourses in youths' constructions of a disability identity and the presence of a disability hierarchy among youth with disabilities. This being said, we are not suggesting that the participants in the present study are the passive dupes of ableist discourses. Rather, youth appropriated dominant discourses strategically, using them as a resource to resist constructions of youth with disabilities as a homogenous group and the imposition of a disability identity that is unitary, simplistic and unfavorable. In general, youth both resisted and rearticulated ableist discourses and positioned themselves as either "not-so-disabled" or as "able" subjects within such discourses. Regardless of the effects of such discursive practices, the intentions were to challenge stereotypes and more accurately re/present youth with a disability.

Conclusions

In our study, participants' narratives on health, fitness and disability pointed to the often contradictory ways in which youth discursively construct disability and negotiate their identities. These youth performed varied and changing identities within multiple and often competing discourses of dis/ability, masculinity and femininity. From their narratives, it was apparent that the participants were hailed by dominant discursive formations. For example, their dissociation from other youth with disabilities and their rejection of disability as a self-identifying element revealed the influence of ableist discourses in their constructions of disability. We argue, following Deal (2003) and Finkelstein (1993) that in distancing themselves from other youth with disabilities, participants may have understood themselves as closer to a socially constructed able-bodied "norm."

However, our findings also propose that youth are not the passive victims of dominant ableist discourses. As Foucault has suggested, points of resistance are present in every structure of dominance, every power network:

Hence there is no single locus of great Refusal, no soul of revolt, source of all rebellions. . . . Instead, there is a plurality of resistances, each of them a special case: resistances that are possible, necessary, improbable; others that are spontaneous, savage, solitary, concerted, rampant, or violent; still others that are quick to compromise, interested, or sacrificial (1978, pp. 95-96).

This seems to be the case here, and like in Priestley's study (1999), our participants are continually active in resisting, reconstructing, and responding to dominant discourses in a multiplicity of ways that coincide with their experiences and realities. These participants

are not only aware of the prevalence of oppressive and disempowering stereotypes of disability, they spend a great deal of energy resisting the imposition of a negative disability identity and opposing assumptions that disability is the only or most important aspect of their identity.

The ways in which these Canadian youth with a mobility impairment resisted others' representations of them were indicative of the heterogeneity of this group of youth. For some youth, performing "ability" through physical activity and sport was an important way of defying oppressive stereotypes. For others, engaging in disability activism allowed them to draw attention to marginalized experiences of disability. For yet others, avoiding the issue of disability or strategically re-articulating elements of dominant discourses of disability to disassociate themselves from negative stereotypes were ways to resist being imposed a negative disability identity. These findings generally point to the influence of ableist discourses in North America and are indicative of the scarcity of alternative discourses of disability available to youth in Canada.

Overall, our study pointed to the diversity of experiences and understandings of disability, and the complex and fluid ways in which the identities of youth with a mobility impairment are constructed and performed. We are hopeful that in showcasing the voices and perspectives of youth themselves, this study will be complicit in challenging dominant constructions of what it means to have a disability and creating a space for alternative discourses to become influential.

¹ Where names are mentioned in the text, we have used youth's self-chosen pseudonym.

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CHAPTER VIII

CONCLUDING REFLECTIONS AND NEW BEGINNINGS

Over the course of the last few years, media representations of people with disabilities have increasingly made their way into the homes of Canadians. Typically, images of youth with disabilities have been publicized through charity telethons and fundraisers. The youth portrayed through these media are characteristically angelic, innocent, cute, dependent on others, and victims of some tragedy beyond their control. After all, if we didn't view them this way, why would we be motivated to send money? More recently, 2004 and 2005 have been years marked by a celebration of the extraordinary accomplishments of several North Americans with a mobility impairment. In the United States, the passing of "Superman" Christopher Reeve was an occasion to remind viewers of his surprising recuperation after injury and of the sacrifices that his wife and family have made following his accident. The opportunity was also used to suggest the importance of supporting stem cell research for spinal cord injury. In Canada, the 25th anniversary of Terry Fox's Marathon of Hope in April of 2005 was underlined by discourses of heroism and courage, reminding us of the importance of perseverance, hard work and bravery. In addition, Montreal native Chantal Petitclerc's five gold medals at the 2004 Paralympic Games and her refusal to share Canada's Female Athlete of the Year award with a non-disabled athlete encouraged us to question the secondary status on Paralympic athletes.

While it may be argued that representations of "disabled heroes" are at most a step forward for disability rights and, at least, a step away from negative and "tragic"

portrayals of youth with disabilities, I remain unconvinced that people with disabilities are finally breaking into the public domain. While Terry Fox, Chantal Petitclerc and Christopher Reeves may be inspiring and act as positive role models to youth with disabilities, I am not persuaded that these prominent North Americans speak to the diverse realities of youth with a mobility impairment. I agree with Wendell (1996) that, in the absence of alternative images of disability, images of the disabled hero may give the impression that anyone can “overcome” physical impairment. In contrast to the youth in my study, disabled heroes tend to have exceptional economic, social or physical resources. For example, in watching Petitclerc, I am reminded of a conversation I had with Einstein within which he explained the following to me:

I tried to get into like some sledge hockey but I can't play that because I have a weak arm, and it's just not really helpful. But all my life I've seen track and field and I really want to get into that. I tried to fit into one of those chairs. I can't fit, but my upper body can work in those chairs but just not the lower. . . And like, your body has to be really close cause of the wind resistance, and you are really like scrunched down and your legs are behind like, underneath, and like you're literally folded down and forced to push. But it helps with like going quick and that stuff.

For Einstein and others, images of extraordinary people with disabilities may spark their interest in disability sport or encourage them to become involved in fundraising or activism; however, images of the “disabled hero” may also be reinforcing a “disabled ideal” from which numerous youth may always be excluded. This reflection has led me to

wonder where are the voices and images of the incredible youth with disabilities that I have come to know?

A Conversation with Cerebral Palsy

Well, cerebral palsy—
Do you mind if I call you CP for short?—
You've been with me for fourteen years:
My constant companion.

I accept that you are with me,
Yet I resist you.
I ignore you most of the time, CP.
I hope you don't mind.

Why am I,
Of all people,
Stuck with you?

It's not fair!
Oh, well.
That's the way it's gotta be.

I must thank you, though, CP.
If it wasn't for you,
I wouldn't be me.

Because of you,
I am more determined than ever
To make something of myself:
To succeed.

- Jill Allen

The poem above, written by a young American woman with cerebral palsy (see Wehmeyer, 2003, pp. 140-143) is included here, as it gives a voice—this silenced voice to which I alluded earlier—as well as it provides a welcomed example of an alternative to the dominant representations of youth with disabilities present in both scholarship and popular discourse. What is significant about Jill's poem is that it points to the complex

and often contradictory ways in which youth with disabilities negotiate identity and construct disability. On one hand, Jill specifies that without cerebral palsy, she would not be the person that she is. Similarly, the youth in my study indicated, in their own language, that experiences of impairment were significant to the formation of their subjectivity and identity. On the other hand, both Jill and the participants in my study resist viewing themselves as “disabled teens,” refusing to let impairment or experiences of ableism control their lives and identities. Jill’s poem was inspirational to my own writing and confirmed in me the importance of writing texts that privilege the words and experiences of youth themselves. I hope that my work, like Jill’s poem, offers a counter-hegemonic view of youth with physical disabilities.

The two articles presented here focused on youths’ narratives on health, fitness and disability. In my analysis of these narratives, I endeavored to answer three basic questions: How do youth with a mobility impairment construct health, fitness and disability? From what discourses do they draw in their constructions of these concepts? What is the role of dominant ableist discourses in their negotiation and construction of identity and subjectivity? My findings were generally to the effect that while youth with a mobility impairment had experiences and drew on discourses that were marginal (in relation to mainstream representations of health, fitness and the “healthy” body), their ideas about health and fitness were strongly influenced by healthism and tied up, at times, with larger discourses of conventional masculinity, femininity and ableism. Youth also rearticulated ableist discourses in their constructions of disability. Their differentiation from the “typical” youth with a disability as well as their resistance to self-identifying as a person with a disability were indicative of the power of ableist discourses in their

constructions of a disability identity. This finding may be particularly concerning for the future of disability activism as such discourses may cause great division among the disability community.

Taken together, the results presented in my two articles suggest that the adolescents who participated in this study are hailed by prevailing discourses of health, fitness, masculinity, femininity and ability in their constructions of health, fitness and disability. However, it is also apparent that youth are not passively taken-up by dominant discourses. On the contrary, my results suggest that youth selectively appropriate and strategically implement elements of dominant discourses in order to resist mainstream stereotypes of disability and to construct and perform alternative disability and gender identities. The participants were continually active in resisting, reconstructing, and responding to dominant discourses and they did this in a multiplicity of ways that coincided with their experiences and realities. This finding gives me hope, as for some youth, resistance involved drawing attention to their marginalized experiences of disability and, hence, carving out a place for alternative discourses of health, fitness, disability and gender.

Throughout the completion of this thesis, I came to recognize the importance of feminist poststructuralism and disability theory, appreciating the ways in which they complement each other. Feminist poststructuralism allowed me to account for disability as a discursive process that is fluid and changing. Through the concept of discourse, I learned how particular meanings are given prominence at specific times and in specific contexts and, thus, I came to better understand and appreciate the variety and often contradictory ways in which youth with a mobility impairment construct subjectivity and

negotiate identity. While feminist poststructuralism emerged as necessary to my understanding of how youth construct health, fitness and disability, I realized that this theory on its own was not sufficient in capturing and explaining the lived and embodied experiences of disability and impairment. In addition to my focus on language and discourse, I benefited from disability theory, which allowed me to also pay attention to “the body: its materiality, its politics, its lived experience, and its relation to subjectivity and identity” (Garland Thomson, 2002, p. 9). Of late, disability theorists have considered poststructuralism, bringing to it the lived experiences of the impaired body. They were good guides. Indeed, through my interactions with youth, it became clear that disability, while performed, was also visceral. Performances and constructions of disability, health and fitness were inseparable from youths’ material experiences of their bodies. Simply put, my research allowed me to realize that disability, health and fitness are more than discursive processes, they are also embodied ones.

In conclusion, the ways in which Canadian youth with a mobility impairment constructed health, fitness and disability were indicative of the heterogeneity of youth with disabilities. The youth in this study performed varied and changing identities, drawing on multiple and often competing discourses of dis/ability, masculinity, femininity and healthism to construct their subjectivities and identities. In that respect, this research has pointed to the importance of socio-cultural contexts in the discursive constructions of health and fitness; it has also indicated that prevailing discourses have a varied but crucial impact on youth.

In North America, ableist discourses seem to have great influence on youth, which is not only indicative of the subjugation of bodies that fall outside the realm of “normal”

in our society, but also of the lack of alternative discourses of dis/ability available to youth in Canada. I argue that in order for hegemonic (i.e., ableist and healthist) discourses to be deconstructed and alternative discourses brought to light, the voices of youth with a disability need to be privileged within scholarship as well as within popular cultural “texts.” I do hope that in showcasing the voices and perspectives of youth themselves, the present contribution, though modest, will be complicit in challenging dominant constructions of health, fitness and disability.

CHAPTER X

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CHAPTER XI

APPENDIXES

APPENDIX A

INTERVIEW GUIDE

1. Constructions of health

- 1) When you see or hear the word "health", what comes to your mind?
- 2) What does "being healthy," mean to you?
- 3) What are key words that you would use to define health?
- 4) What qualities would a healthy individual have?
- 5) How/why is being healthy different/similar for men and women?
- 6) If your community leaders, your physical education teachers, or your parents could do anything to make you healthy, what would you ask them to do?
- 7) Do you care about health? How much? Why?
- 8) What does it mean when someone is unhealthy? Do you often meet people who are unhealthy? How do you think they got to be unhealthy?

2. Sources of the constructions of health

- 1) Where do you think your ideas on health come from? Why?
- 2) Where do you get information on health? Is there a lot of information out there? Are you interested in this information? Why/why not?
- 3) How do you learn how to do healthy things? How do you learn about unhealthy things?
- 4) Does the media help you to do healthy things? Why/why not? How? Which kinds of media?

3. Constructions of fitness

- 1) What does "being fit" mean to you?
- 2) What are key words that you would use to define fitness?
- 3) What qualities would a fit individual have?
- 4) How/why is being fit different/similar for men and women?
- 5) What do you think of women who engage in fitness and sport?
- 6) Do you think it should be a priority for people?
- 7) If your community leader, or physical education teacher, or your parents could do anything to make you fit, what would you ask them to do?
- 8) Do you care about fitness? How much? Why?
- 9) What does it mean that someone is not fit? Do you often meet people who are not fit? How do you think they got to be unfit?

4. Sources of constructions of fitness

- 1) Where do you think your ideas on fitness come from? Why?
- 2) Where do you get information on fitness? Is there a lot of information out there? Are you interested in this information? Why/why not?
- 3) How do you learn how to get fit? How do you learn about not being fit and the consequences of that?
- 4) Are the media useful? Why/why not? Which ones? How?
- 5) Do you think that the idea of "being fit" is different between adolescents with and without physical disabilities?

5. Integration of the constructions of health in day-to-day life

- 1) Are you concerned about your health? Why/why not?
- 2) Is your health a priority in your life? Why/why not?
- 3) Does health matter to you? Why/why not?
- 4) How do you take care of your health?
- 5) Do you think that you are healthy? What makes you say that?
- 6) What do you do to stay healthy?
- 7) What are the things that prevent you from taking care of your health?
- 8) What do you think you could do to improve your health?

6. Integration of the constructions of fitness in day-to-day life

- 1) Are you concerned about your fitness? Why/why not?
- 2) Is your fitness a priority in your life? Why/why not?
- 3) Does fitness matter to you? Why/why not?
- 4) Do you enjoy fitness activities? Why/why not? Which ones?
- 5) Do you think that you are fit? What makes you say that?
- 6) Why (or why not) do you engage in physical activity? (How does it help you? Why do you exercise? What motivates you?)
- 7) What do you do to stay fit? (Do you exercise alone? How many times a week? Where: fitness club/outside/local gymnasium/school? Is it expensive? Are you aware of facilities, programs?)
- 8) What are the things that prevent you from being fitter? From exercising more?
- 9) What do you think you could do to improve your fitness?
- 10) Do you think that engaging in fitness activities has an impact on health? In what ways?

7. Questions about impairment(s)/ physical disability

- 1) Could you describe your impairment/disability to me?
- 2) For how many years have you had your impairment?
- 3) What does "being disabled" mean to you?
- 4) What are key words that you would use to describe disability?
- 5) When you think of a body with a disability, what comes to your mind?

8. Culture and constructions of health

- 1) Do your parents believe in health the same way you do? Why do you think this is so?
- 2) How are they the same (or different) from your beliefs? Why do you think this is so?
- 3) Do your peers who do not have mobility impairments believe in health the same way you do? Why do you think this is so?
- 4) Do you think that adolescents who do not have mobility impairments have different beliefs/ideas about health than you? What are they?
- 5) What does a healthy body look like to you?

- 6) Do you think that adolescents who do not have mobility impairments have different ideas about what a healthy body looks like than you? What are they?
- 7) Do you think that your disability plays a role in your health habits? How?

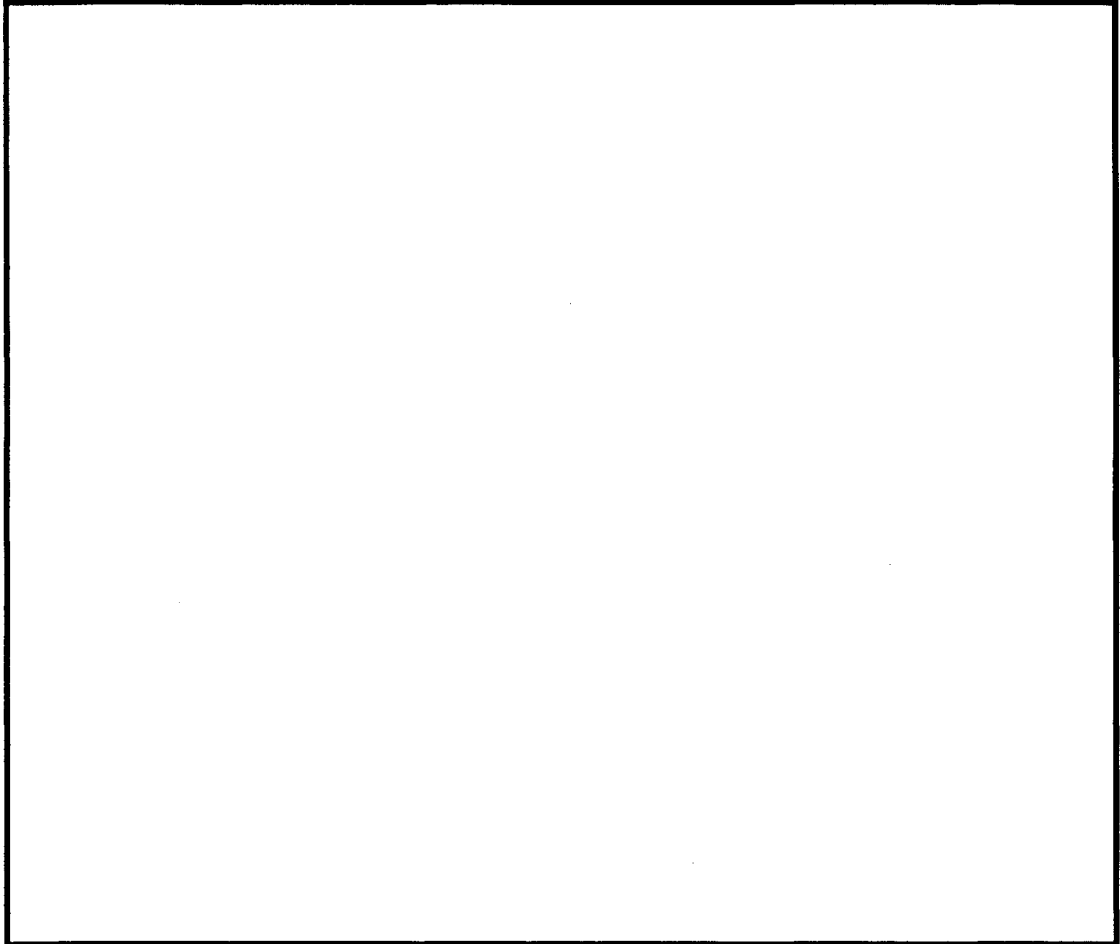
9. Culture and constructions of fitness

- 1) Do your parents believe in fitness the same way you do? Why do you think this is so?
- 2) How are they the same (or different)? Why do you think this is so?
- 3) Do your peers who do not have mobility impairments believe in fitness the same way you do? Why do you think this is so?
- 4) Do you think that adolescents who do not have mobility impairments have different beliefs/ideas about fitness than you? What are they?
- 5) What does a fit body look like to you?
- 6) Do you think that adolescents who do not have mobility impairments have different ideas about what a fit body looks like than you? What are they?
- 7) Do you think that your disability plays a role in your fitness habits? How?

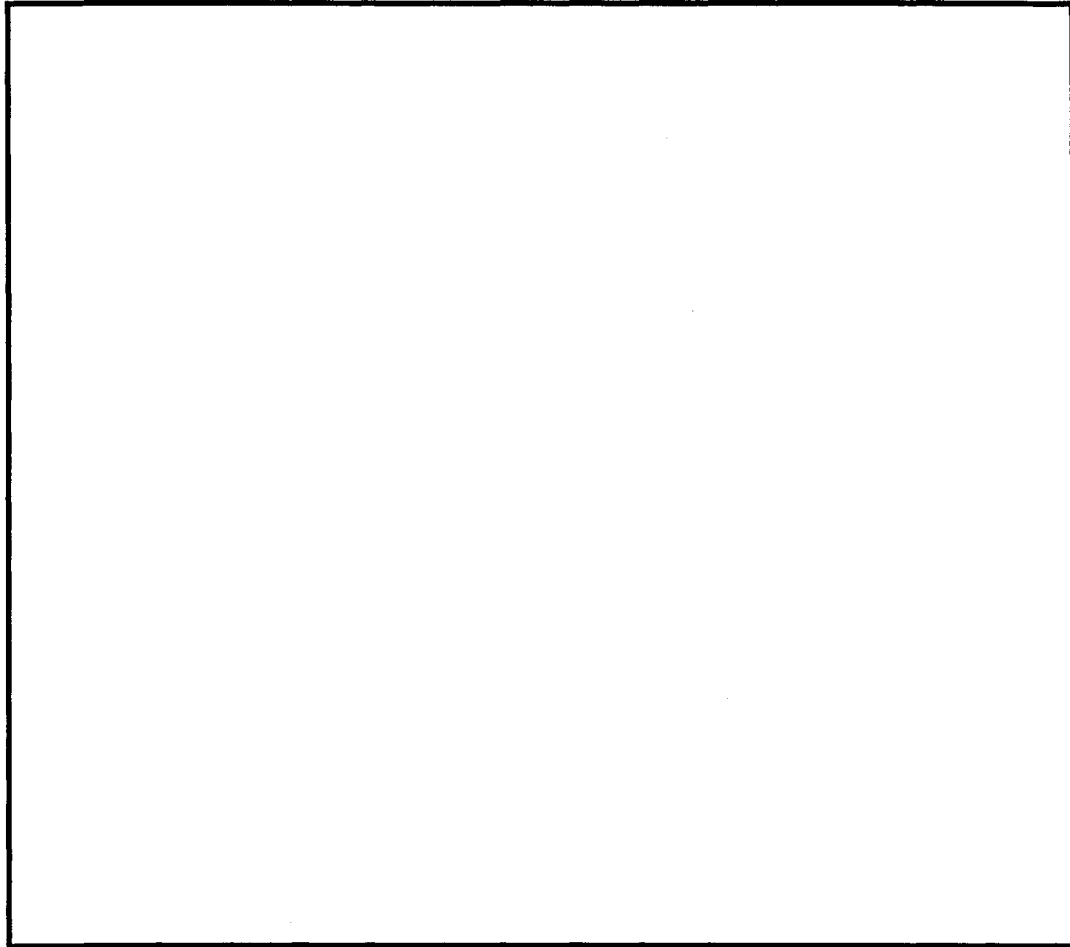
APPENDIX B

WRITE, DESCRIBE AND DRAW SCHEDULE

In the box below, please create a drawing of an healthy adolescent.



In the box below, please create a drawing of an adolescent who is fit.



On the lines below, please identify the top three people or places that you get your ideas about health and fitness from.

APPENDIX C

APPENDIX D

**LETTER OF PERMISSION TO ACCESS COMMUNITY CENTER
(Official Letterhead of Organization)**

Date

Dr. Geneviève Rail
Department of Human Kinetics
University of Ottawa
Ottawa, Ontario
K1H 8M5

Dear Dr. Rail:

Our association carefully considered your research proposal. Our community welcomes the opportunity to participate in the research on health and our young people. Our community, however, understands that the decision to participate, or decline to take part in the study, is left completely to the discretion of the young people and their parents. Our association is under the assumption that any issues that arise from these interviews will be the responsibility of the researcher and not of the association or its staff. Under these conditions, we authorize you to come to our community activities in order to recruit participants for your study.

Our association also grants you permission to access one of the rooms or a quiet area in our center for your interviews with students with a mobility impairment on the following days _____, at the following times _____, from May to December 2004. Please let us know in advance when you consult with students in our center.

Our association is interested in the results of the study, and we would be more than happy to see a summary of the results upon completion of the study.

Sincerely,

(Name of Community Leader)
Community Leader
(Name of Community Center)

APPENDIX E

young people's ideas of health and fitness. With this specific information, we could develop knowledge that will assist physical educators, community leaders and health professionals in their intervention to improve the health and well-being of adolescents with physical disabilities.

Procedure

a) Semi structured, individual interview: Each participant will be invited to take part in an individual interview. All questions will revolve around ideas about health and fitness, and will also discuss their ideas and perceptions concerning disability and impairment. The individual interview will last approximately 60 minutes.

b) Individual Journals: Each participant will be invited to make a drawing of a "healthy" adolescent and a "fit" adolescent on paper or to describe these individuals on an audiotape . As well, the participant will be invited to write, or dictate a short story (10-20 lines) about a healthy adolescent, and one about a fit adolescent. The participant will be asked to list their top 3 sources of information on health and fitness.

Nature of participation

I acknowledge that my child will participate in an interview and will write/dictate and/or draw in an individual journal that will be provided by the researcher (e.g. blank cassette tape, or notebook). I am aware that there is very low discomfort involved in this study (my child may experience discomfort that is consistent with speaking in front of an interviewer, and discussing issues of health, fitness, and disability). I acknowledge that my child will have a chance to read the interview transcripts and delete or modify parts of it as he or she deems necessary. I assume that small portions of the interview with my child may be quoted by the researchers.

Audio taping of interview

I grant permission for the tape recording of my child's participation in an individual interview.

APPENDIX F

knowledge that will assist physical educators, community leaders and health professionals in their intervention to improve the health and well-being of adolescents with physical disabilities.

Procedure

a) Semi structured, individual interview: I will be invited to take part in an individual interview. All questions will revolve around ideas about health and fitness, and will also discuss my ideas and perceptions concerning disability and impairment. The individual interview will last approximately 60 minutes.

b) Individual Journals: I will be invited to make a drawing of a “healthy” adolescent and a “fit” adolescent on paper or to describe these individuals on an audiotape. As well, I will be invited to write or dictate a short story (10-20 lines) about a healthy adolescent, and one about a fit adolescent. I will also be asked to list their top 3 sources of information on health and fitness.

Nature of participation

I acknowledge that I will participate in an interview and will write/dictate and/or draw in an individual journal supplied by the researcher. I am aware that there is very low discomfort involved in this study (I may experience discomfort that is consistent with speaking in front of an interviewer, and in discussing issues of health, fitness, and physical disability). I know that I will have a chance to read my interview transcript and to delete or modify parts of it as I see fit. I assume that small portions of my interview may be quoted by the researcher.

Audio taping of interview

I grant permission for the tape recording of my participation in an individual and group interview.

Anonymity and Confidentiality

I understand that all materials collected as a result of my participation will be used only for research purposes, that they will be available only to responsible professionals and that my anonymity and confidentiality will be protected at all times. I know that if small portions of the

APPENDIX G

INFORMAL PRESENTATION TEXT

Hello, good afternoon/morning/evening,

My name is Morgan Seeley and I am a graduate student at the University of Ottawa. I am here today because I am involved in a research project conducted by my supervisor at the university. Our project is to study perceptions of health and fitness among young adults with mobility impairments.

Today, I am looking for adolescents between 13 and 17 years old who consider themselves to have a mobility impairment/disability to take part in an interview that should take about an hour to an hour and a half. The interview is about health and fitness, what it means to you, where you get the ideas from and questions like that. I am looking for volunteers who would be interested in answering these questions. The interview would be confidential and we would use a fictitious name to report our results.

Those of you who are interested in participating in the interview, please fill out this recruitment form and I will contact you as soon as possible to discuss the study in further detail. If you are still interested at that point, then we would discuss a place and time for the interview that is convenient for you and that you feel comfortable with.

Please feel free to ask me any questions that you may have regarding this research project.

Thank you for your time and consideration.

APPENDIX H

PARTICIPANT RECRUITMENT FORM

Title of Study: Constructions of health and fitness among adolescents with a mobility impairment

1) NAME: _____

2) AGE: _____

3) GENDER: _____

4) PLEASE BRIEFLY DESCRIBE YOUR IMPAIRMENT(S):

5) How well do you understand English? Put an "O" where you fit on this line:

1	2	3	4	5
<div style="position: absolute; left: 0; top: -5px; border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div> <div style="position: absolute; left: 25%; top: -5px; border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div> <div style="position: absolute; left: 50%; top: -5px; border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div> <div style="position: absolute; left: 75%; top: -5px; border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div> <div style="position: absolute; right: 0; top: -5px; border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div>				Very well
Not so well				

6) How well do you communicate verbally? Put an "O" where you fit on this line:

1	2	3	4	5
<div style="position: absolute; left: 0; top: -5px; border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div> <div style="position: absolute; left: 25%; top: -5px; border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div> <div style="position: absolute; left: 50%; top: -5px; border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div> <div style="position: absolute; left: 75%; top: -5px; border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div> <div style="position: absolute; right: 0; top: -5px; border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div>				Very well
Not so well				

7) Are you interested in participating in this study? Yes: _____ No: _____

8) When is the best time to contact you?

Morning: _____ Afternoon: _____ Evening: _____

9) What is your phone number? _____

Thank-you very much for your time and consideration.

APPENDIX I