



Disability, rehabilitation and social control: A Foucauldian perspective.

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Abstract

Rehabilitation is a concept that embodies all of the key elements of the social construction and constitution of disability. It is embedded within rehabilitation that individuals must attain productivity through the disciplines that stem from 'employment' and adhering to a 'regular work timetable'; it works to govern individuals at a distance by immersing them in a field of 'helping' and 'professional' expertise which serves to 'help' guide their aims and actions, and it is representative of the imperative placed on each and every citizen of advanced liberal democracies to strive to emulate 'the norm'. Utilizing a Foucauldian genealogical perspective, this essay argues that the concept of rehabilitation has been historically employed as a strategic mechanism for greater social control and governance of individuals with disabilities by practices of 'normalization' and 'adjustment' via the diffuse network of 'power relations' fundamental to contemporary social liberal societies such as Australia.

Key Words: Sociology of disability; rehabilitation; social model; Foucault; governance; social control

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Rehabilitation is based on a principle of reform very similar in many ways to that which has informed the operation of the penitentiary system as explored by Foucault (1977c) in *Discipline and Punish*. In both these contexts, rehabilitation's significance relies, not on its ability to actually eliminate the problems it is supposedly designed to address, but to reinforce a system of disciplinary power based on such classifications:

One would be forced to suppose that the prison, and no doubt punishment in general, is not intended to eliminate offences, but rather to distinguish them, to distribute them, to use them: that it is not so much that they render docile those who are liable to transgress the law but that they tend to assimilate the transgression of the laws in a general tactic of subjection (Foucault, 1977c, p. 44).

In keeping with the above, Rabinow & Dreyfus (1982) argue that “penitentiaries, and perhaps all normalizing power succeed when they are only partially successful” (p. 196). This is just as pertinent to the physical, behavioral and psychological rehabilitation that is imposed upon people with disabilities as it is to the ‘moral rehabilitation’ designed to ‘reform’ criminals. The ideology of rehabilitation can *only* continue to be justified as a principle for reinforcing certain standards if those standards consistently fail to be met.

In this way it can be argued that the ‘delinquent’ and the ‘disabled person’ serve a similar purpose in society. Both classifications are based on the idea of deviation from acceptable standards (Illich, Zola and McKnight, 1977) and are seen to justify disciplinary measures that range from surveillance and incarceration to self-government through the guidance of ‘helping experts’ (Zola, 1982). Foucault (1977c) argues that “the prison cannot fail to produce delinquents” (p. 266). This is because the punitive system relies on the naming of a group formerly not conceived and then proceeds to marginalise its constitutive population in such a way as to leave them with no alternative other than to behave in the ways prescribed by their classification. Foucault (1991e) further argues that:

For the observation that prison fails to eliminate crime, one should perhaps substitute the hypothesis that prison has succeeded extremely well in producing delinquency... So successful has the prison been that, after a century and a half of "failures," the prison still exists, producing the same results, and there is the greatest reluctance to dispense with it... (pp. 231-232).

The same can be said for the relationship that has developed between rehabilitation and disability in that rehabilitation has been extremely successful in ‘producing’ and ‘reproducing’ disability in its contemporary form (Dean, 1995, 1996, 1997, 1998, 1999). True to its grounding in medical discourse, rehabilitation focuses on disability as an individual problem which requires individual change (Shakespeare, 1994, 1995(b)). As with delinquency, which is seen to be an individual aberration, rather than a phenomenon that has its roots in social inequality, the social origins of disability are often largely ignored (Barton, 1996; Oliver and Barnes, 1988; Oliver, 1996). Consider the following description of the aims of rehabilitation:

Rehabilitation is a goal-oriented and time-limited process aimed at enabling an impaired person to reach the optimum mental, physical and/or social functional level, thus providing the individual with the tools to change her or his own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example, by technical aids) and other measures intended to facilitate social adjustment or re-adjustment (Healey, 2000, p. 2).

Under this definition, disability is located within the individual and remedial action is diverted to the person concerned as a matter of individual responsibility. There is often no consideration that disability is created by a ‘social disabling environment’ that ‘excludes’ people who do not ‘fit the norm’ and, as such, rehabilitation is assured of maintaining its power to ‘define, target and marginalise’.

When viewed from Foucault's (1977b) perspective that the world, as we understand it today, has been built, not from a firm and sequential continuity, but from a fragile and discontinuous lineage of “accident and succession” (p. 142), rehabilitation can be understood as the result of a collision of elements which, if the conditions for their fusion had not been as they were, may have dispersed or merged in a different way. Yet, due to a series of not always connected, yet mutually reinforcing events, such as the advent of modern warfare, the development of workers' compensation legislation, the expansion of medical discourse, the birth of the welfare state, and the emergence of a range of health and welfare professionals whose purpose was to facilitate the lives of the disadvantaged, rehabilitation evolved as a potent governmental tool (Dean, 1995, 1996, 1997, 1998, 1999; Illich and McKnight, 1977; Zola, 1982). Although work-related accidents had

already started to attract attention by the end of the nineteenth century, it was not until the First World War that rehabilitation became a primary governmental aim. Thousands of men who would once have died on the battlefield were saved to become amputees and otherwise disabled veterans and, with the boom created by the wartime upsurge in manufacturing, there was a greater need than ever to restore as many people as possible to 'their place within the system' of disciplines that comprises the labor force (Kewley, 1973; McDonald, 1976; Roe, 1976).

The response to the disabilities incurred during the First World War was largely mechanical. Technology could be utilized to restore the function of those wounded by battle. Prior to this the only aids available to the 'cripple' were the wooden leg and the crutch, but after the horrendous casualties wrought by the war in Europe, the replacement of body parts became big business (Barton, 1996). But prosthesis is not only the pieces of wood, iron, now plastic that replace the missing hand or foot. It is also the very idea of replacement. The image of the maimed person and of the society around him/her becomes prosthetic. Replacement, re-establishment of the prior situation, substitution, and compensation - all this now becomes possible language (Stiker, 1999, pp. 123-124). Indeed, prosthetics formed part of what was to become a larger rationale. Rehabilitation was to develop into a complex field of expertise covering a wide range of discourses whose purpose was not only to 'restore' the patient's former appearance and function, but also to emphasize ways of thinking and behaving which were consistent with 'normality' (Dean, 1995, 1996, 1997, 1998, 1999; Oliver, 1996; Shakespeare, 1994, 1995(b)).

The emergence of the social survey and statistics in the late 1940s helped to bring chronic illness and disability even more fully under the gaze of medicine and its associated 'helping' discourses (Armstrong, 1983, 1995; Illich, Zola and McKnight, 1977). With this influx of statistical input, the knowledge base of these new fields was able to expand very rapidly and it was at this time that the 'helping professions' associated with rehabilitation gained a foothold within the institutions of higher learning (Crewe and Zola, 1983; Delong, 1978). A course for social work was set up at the London School of Economics in 1954 (Drake, 1999, p. 53), a World Federation of Occupational Therapists was formed in 1952, and in 1954 the first international congress of occupational therapists was held at Edinburgh (Pound et al., 1997). Since then, rehabilitation therapy has occupied a key

place in the assembly of rehabilitation professions given its focus on returning the disabled or chronically ill person to a state of normality in relation to both work and living skills, and its “knowledge of anatomy, physiology, medicine, surgery, psychiatry, and psychology” (ibid. p. 335).

This growth of professional intervention into the lives of disabled people was accompanied by an explosion of the literature on rehabilitation. Barker et al. (1953) refer to “an annotated bibliography of 5000 items issued during the years 1940-1946” and remark that “the publication has certainly not been less in later years” (p. 366). Anspach (1979) suggests that these texts are “infused with optimism and a belief in human perfectibility, imbued with a belief in the efficacy of individual effort” and, in consequence, “rehabilitation agents promulgated rhetoric of ‘coping’ with disability and ‘adjustment’ to the prevailing normative structure” (p. 771). While the words ‘coping’ and ‘adjustment’ may seem an innocent enough description of the processes through which a disabled person must pass to overcome his or her disadvantage, they are loaded with assumptions based on the belief that disability is a ‘personal deficit’ to be overcome from within.

The ways in which these assumptions enter texts (even those supposed to take issue with the medical model) can be illustrated by the work of Anselm Strauss (1984; 1975). Strauss's text on the experience of chronic illness and disability intended to educate the full gamut of health professionals who were increasingly engaging in the rehabilitation business. In his discussion of 'normalization', for example, he observes that those who successfully adjust:

... simply come to accept, on a long-term basis, whatever restrictions are placed on their lives. Like Franklin Roosevelt, with his polio-caused disability, they live perfectly normal (even supernormal!) lives in all respects except for whatever handicaps may derive from their symptoms or their medical regimens. To keep interaction normal, they need only develop the requisite skills to make others ignore the differences between each other in just that unimportant regard (p. 87).

Strauss's work is to be applauded, along with the work of other symbolic integrationists such as Goffman (1963) and Charmaz (1983, 1987), for its challenge to medicine's preoccupation with the functional aspects of disability at the expense of the ways in

which people actually ‘experience’ it. However, while such authors focus on the ‘personal’ ramifications of disability, they neglect to analyze its social construction and, as Armstrong (1983) argues, “the effect of their stance is to have strengthened the power of the gaze of the new medicine to the essentially subjective” (p. 115).

Over the past three or four decades the concepts of ‘rehabilitation’ and ‘normalization’ have become virtually synonymous (Barton, 1996; Dean, 1995, 1996, 1997, 1998, 1999). The term ‘normalization’ was first used in Scandinavia in the 1950s by Karl Grunewald and Bengt Nirje in Sweden and Nils Bank-Mikkelsen in Denmark (Cocks and Stehlik, 1996, pp. 19-20). It began as a concept used to describe the assimilation of intellectually disabled people into the community as a function of deinstitutionalization, but it was picked up by Wolfensberger in the late 1960s and has continued to influence the development of general rehabilitation policy since that time (Wolfensberger, 1969, 1972, 1992). In essence, ‘normalization’ is an open acknowledgment of rehabilitation's aim to ‘reinforce’ certain standards of behavior, function and appearance among those to be ‘assisted’ and ‘reformed’.

Another feature of normalization is that it invariably falls short of its stated goals with the result that disabled people continue to present a cogent reminder of the ‘other’ side of normality (Oliver and Barnes, 1988; Oliver, 1996). Two recent studies illustrate this. The first, by Ochs and Roessler (2010), concludes that people with disabilities have not been as successful as their non-disabled cohorts in finding employment because they lack the characteristics of “career maturity” and “personal flexibility” (p. 170). The students in this study were measured for these competencies using a range of scales that attach numerical values to the qualities being assessed. From these measures it was concluded that disabled students need to be taught new skills which will enhance their inferior levels of “career decision-making self-efficacy beliefs”, ‘career outcome expectations’, “intentions to engage in career exploratory beliefs” and “vocational identity” (p. 175). Nowhere is it mentioned that disabled people may in fact be faced with lower employment rates due to job discrimination and/or disabling social and environmental constraints. The assumption is, as always, that the problem, and therefore the solution, lies within the “individual”.

The second study by Livneh (2011) explores the ways in which disabled people adapt to their conditions and circumstances according to another quantitative measure, the QOL. QOL is an acronym for "quality of life" and is based on a variety of scales that ascertain "one's ability to effectively re-establish and manage both the external environment and one's inner experiences (cognitions, feelings, behaviors)" (p. 156). Someone with a high QOL is 'performing well' in a normative sense and is seen to be 'adapting comfortably' to disability or chronic illness. On the other hand, someone with a low QOL is exhibiting thoughts and behaviors that are 'problematic' for their rehabilitation. Once again, the emphasis here is on 'personal' adjustment that completely neglects the socio-political context in which disability is played out. The calibration of individuals according to these precepts serves the purpose of 'reinforcing' the norm, not of actually offering disabled people a better 'quality of life'.

Studies such as these demonstrate that the quantification of 'human attributes and experience' has come a long way since its instigation in demographic statistics in the eighteenth century (Dean, 1995, 1996, 1997, 1998, 1999). Now calculations are made, not just about the more abstract category of the population, but also in relation to individuals, marking their inadequacies, mapping their desires and delineating their needs. When numerical values are attached to concepts such as 'career maturity', 'personal flexibility', 'vocational identity', 'coping', 'adjustment', and, more broadly speaking, 'quality of life', they tend to become indelible measures of disabled people's identities, abilities and possibilities (Barton, 1996; Illich, Zola and McKnight, 1977; Zola, 1982). And, as with the IQ test, it is difficult or even impossible to escape their definition once one is marked by these scores.

In conclusion, through the development of modern forms of governance and the fields of knowledge and expertise that fuel them, those who are viewed as physically incapacitated are 'assigned' an 'identity' and a 'social location' that marks them as Other: other than 'normal'. To recognize, via genealogy, that this identity is a social construction is to present a serious challenge to the biomedical/ psychological view which assumes that the inner distress and self-esteem problems which accompany disability are 'natural' reactions to 'personal' tragedy which must be remedied by way of rehabilitation. A genealogical view of rehabilitation demonstrates, conversely, that these 'scientifically'

based 'responses' to illnesses and impairments are, in actuality, the basis for the creation of the category of disability and the imposition of a marginalized status on those medically defined as 'disabled'. The 'disabled identity', therefore, does not stem from an aberration of the individual psyche; it emerges from the calibrations, inscriptions and disciplinary logics of rehabilitation that have been devised to influence the shaping of a 'preferred way of living and being'.

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