(Dis)ability

Dominant narratives of disability often rely on language that communicates a sense of danger, deficiency, limitation, or impairment. Such language frames disability as inherently negative and reinforces ableist assumptions that conflate disability with suffering, tragedy, or failure (Gary, 2021). Arriving from this lens, disability is received as a disruption, an interruption, and a departure from convention. Further, the personalization and individualization of disability by the use of such language, locates disability within a singular subject—mobilizing the preservation of collective defense against the anxiety of becoming said subject (Babbar, 2025).

Titchkosky (2011) notes that using the individualistic–coded language of "who" and consequently identifying "who" is disabled is in itself an act of sorting and drawing lines of separation amongst masses of bodies based on their deviance and departure from "normalcy". In this way, normate culture reproduces itself and lives in perpetuation by continually defining certain bodies as existing within and/or outside of the margins. Seeing as how the culture of individualism requires the inquiry and identification of a "who" (and object), it would be a disservice regarded as purely an individual matter. Disability only gains meaning *in relation to* the able-bodied embodiment. In relation to the body that is received as idealistic, impermeable infallible, and irresistible. This understanding of disability is then utilized to orient the self and the other.

Disability is therefore relational and constructed socially through interactions between people and structures. Yet dominant discourse rarely acknowledges this relational dimension. Instead, disability is treated as an isolated personal condition, obscuring the collective ways

society creates and sustains exclusion. Having said that, on occasions that it is used to relate to people, the interaction typically devalues a perceived difference–trenching our ideas of disability as little more than a problem or a lack (Gary, 2021).

The reaches of whiteness as an ideology plays a pivotal role in constructing our ideas surrounding normalcy, intelligence, value, and worth. This is through its location of the white male body as normal and ideal in comparison to other bodies (Babbar, 2025; Reynolds, 2022). The second we start making distinction based on value and worth, we start engaging with the logic of capitalism. The devaluation of disability is inseparable from broader systems of power such as white supremacy, patriarchy, and capitalism. These systems establish ideals of the desirable body: productive, independent, rational, non-racialized, masculine, cisgender, heterosexual, impenetrable, and economically useful. Bodies that do not conform to these standards are marked as deficient and therefore disposable.

Capitalist societies organize health and worth around productivity and labor, valuing bodies according to their capacity to produce profit. Disability becomes threatening within this system because it disrupts capitalist ideals of efficiency, independence, and self-sufficiency. The issue is not simply bodily difference itself, but the social and economic structures that determine which bodies are considered useful and which are rendered expendable (Johnson, 2022).

This logic is reinforced institutionally through surveillance and bureaucratic control. In order to access disability-related services, individuals are often required to repeatedly document and prove their limitations. Disabled people are required disclose intimate details about their bodies, narrate experiences of pain or dysfunction, and demonstrate inadequacy to institutions that hold authority over resources and care. Shildrick and Price (1996) argue that this process fragments the body through the “objectifying gaze” of medical and bureaucratic systems that

frames these bodies as needing constant evaluation and control. The disabled person is encouraged to scrutinize themselves according to external standards of normalcy while simultaneously internalizing the belief that their body requires governance, correction, or management. Rather than empowering disabled individuals, these systems frequently reinforce dependence, surveillance, and self-objectification.

Institutions insist on providing the disabled person with choice and control over the information that they offer about their bodies. But is it really a choice when withholding disclosure is understood as an insufficient performance of inadequacy, leading to fewer services being provided (Babbar, 2025)? Is it a choice when the system is designed to give you as little as possible because your existence is considered an imposition? Placed in the contradictory position of having to emphasize their limitations enough to be recognized as "disabled enough" while also resisting stereotypes of incapacity in order to participate socially, disabled individuals often end up internalizing ableist standards of existence. Such individuals are than prone to evaluate themselves through a lens that did not even incorporate them in its formation.

The stigma attached to disability intensifies at the intersections of race, gender, sexuality, and body size. Critical disability scholars have demonstrated that bodies marked with disability and female-ness, racialization, fatness, age, and queerness experience heightened forms of devaluation because their bodies already trouble dominant social norms and place pressure on expectations. Disabled women, for example, are often desexualized or viewed solely as recipients of care rather than as autonomous subjects capable of intimacy, caregiving, or reproduction. Cultural expectations surrounding femininity and womanhood remain deeply tied to ideals of bodily control, beauty, and reproductive capacity. When disabled bodies fail to align

with these expectations, disability becomes framed not only as bodily difference but also as a disruption of identity itself (Lindgren, 2004).

Bodies that are disabled, racialized, fat, queer, and/or aging are left with choice but to experience themselves through shame and badness because the dominant culture positions bodily difference as something requiring correction, concealment, or transcendence. The violence of ableism, therefore, does not emerge solely through exclusionary structures but also through the internalization of bodily shame and the constant pressure to apologize for existing outside of social ideals (Taylor, 2018).

To protect themselves from the being consumed by the projected shame and sense of madness, disabled individuals are pressured to either overcome their disability in inspirational ways or conceal it (Watermeyer, B., Hunt, X., Swartz, L., & Rohleder, P. 2019). In response to, some disabled people may choose to separate disability from their sense of self or avoid disclosing their disability altogether. This is particularly true for individuals with invisible disabilities, who may strategically conceal aspects of their identity to avoid marginalization. Yet invisibility also produces forms of isolation and misrecognition, as individuals navigate spaces where their experiences are invalidated or rendered unintelligible because they do not visibly conform to dominant ideas of disability.

Thinking about disability as a relationship between bodies requires engaging with uncertainty, vulnerability, and variability. It disrupts the fantasy that normalcy is stable, universal, or fully attainable. Bodies are always already fragile, shifting, and interdependent, despite cultural investments and insistence in autonomy, control, and self-sufficiency. Reframing disability as a collective and relational phenomenon makes visible the ways value is assigned to

bodies through systems that privilege productivity, desirability, and proximity to normate ideals, while opening space to resist those hierarchies.

The Policed Bodymind

The colonial operation was founded on constructing the "other" as it was encountered, producing hierarchies of value along lines such as race, gender, and sexuality. Less frequently examined, however, is how colonial systems also construct disability—not merely as an incidental outcome, but as a hierarchical tool. Beyond producing "the mass production of impairment" (Cunneen et al., 2023), colonial logics actively organize bodyminds into hierarchies of ability that justify reverence or domination.

To violate a body and mind is an act of power, of discipline, of punishment, and of subjugation. It is an act that can have visible manifestations and imprint a difference. Crucially, it is an act that communicates a warning by demarcating the consequence of being the "other" and/or resisting coloniality (Babbar, 2025). In this manner, the colonial project positioned the occurrence of disability as being associated with imposition and transgression (Grech, 2015). Disfigurement of the body rendered its unruly and defiant nature visible.

The colonial operation also imposed the domination of temporality—the subjective, experienced, structured, and culturally-mediated sense of time. Indigenous scholars use the concept of settler colonial time to describe the manner through which settler colonial societies impose a linear and progressive understanding of history and time (Rifkin, 2017). Linear time frameworks position time as being sequential and as having causality. Under this framework, colonized land and people are understood as societies that are a part of a past that needed to be

conquered, assimilated, and/or civilized as opposed to being sovereign societies that had ongoing living temporalities of their own. Further, settler colonial temporal logic denotes indigenous people as being regressive or primitive and settlers as being progressive. This obstructs indigenous people from living in the present in the mind of the settler.

Not being able to negotiate their own ways of telling time, indigenous people were forced to observe and practice Greenwich Mean Time—forced into opposing nature and bodily rhythms. Clock time became a tool of oppression. Time became a vector of power that was used to govern bodies, schedules, course of life, and activities. Organizing time linearly, allowed for the governing of bodies for the means of the capitalistic and imperialistic system imposed by settlers (Mills, 2014). It attached bodies to schedules in order to maximize productivity and value while creating strict notions of progress—further entrenching a hierarchy of abilities.

Queer theorist, Elizabeth Freeman (2010), describes this organization of time around capitalistic and heteronormative desires as chrononormativity. Under chrononormativity, bodies are expected to organize their lives around profit and reproduction. As a result, bodies that are not able to meet normative expectations of white, able-bodied, heterosexual, capitalistic adulthood timelines are oppressed and marginalized. Through deviating from chrononormativity, these bodies, are coded as unpredictable, resistant, and irregular (Pearce, 2018)

As disabled bodyminds were historically regarded as dangerous, transgressive, and malicious, they were deemed as further in need of civilizing, discipline, containment, regulation, and intervention. This mobilized a host of practices rooted in the desire to classify, medicalize, pathologize, objectify, punish, and dominate the unruly bodymind. The disabled bodymind became the optimal target for oppression because the medical model offered a supposedly

"scientific" justification for intervention upon bodies deemed pathological (Cunneen et al., 2023). I place "scientific" in quotations deliberately, as these practices emerged alongside the rise of psychiatrization and the consolidation of psychiatric authority in the late nineteenth century.

Psychiatrists—who previously claimed treatment of insanity—started to take an interest in what they termed as idiocy—or what we presently refer to as intellectual disability. Previously, they had deferred the care of such individuals to pastors and teachers. However, state reorganizations of welfare funding transformed disability into a lucrative prospect resulting in psychiatrists broadening their scope of practice. The effects of this were pernicious.

As a tool to make themselves important in the field of disability care, psychiatrists began to invent new categories of existence—new diagnoses that had never existed before. These diagnostic categories drew previously unremarkable and mostly poverty-stricken individuals into systems of surveillance and monitoring. Organizations carrying the seal of legitimacy to provide medical care made generalizations about masses of bodies, whether they were meaningful or not. Despite the lacking evidence of scientific bases, statements from medical authorities were treated as fact and codified into law and policy. This leveraging of medical authority consolidated state power in a manner through which it could determine the fate of a human life. Disability became a political category through which populations could be regulated.

This process intensified the rise of eugenics and the fantasy of a disability-free society. Eugenics positioned disability as hereditary defect rather than as something produced through material conditions, such as poverty, disease, labor exploitation, environmental conditions, or accident. Although medical professionals largely understood that many disabilities emerged from

material conditions, eugenic ideology reversed this causation entirely. Structural violence was rewritten as hereditary failure. In this way, disabled were blamed for their own suffering and eugenics transformed disability into contamination: a threat to the imagined purity and future of the corporal and social body.

It is of import to note that not all bodies are equally held in the court of the carceral mental health institutions. Bodies of color are disproportionately assigned diagnoses that have a higher severity level. Queer bodies are more readily institutionalized or denied care. Fat and disabled bodies are more likely to be pathologized and labeled as being deviant. Femme bodies remain under constant surveillance. The medicalization of bodily difference does not operate neutrally; rather, it reproduces broader systems of racial capitalism, patriarchy, ableism, and heteronormativity.

At times, medical institutions weaponize an individual's symptoms severity to deny them care or justify isolating them—practices that are in attunement with capitalist imperatives. As Beatrice Adler-Bolton writes,

> "Profit lives in the interstitial spaces between bodies, in the counting of bodies, in the measuring of bodies, in the creation and destruction of bodies, in every locus where capitalism touches illness, disease, disability, and death."

Under this logic, health and bodily experiences become metrics to be quantified, categorized, and ultimately monetized. The severity of an individual's symptoms is not merely a bodily reality but a data point in a system that prioritizes financial gain. This creates a paradox where those most in need of care—whose bodies do not fit the capitalist ideal of productivity—are not only

systematically deprioritized or rendered invisible but are also shuffled between medical institutions to maximize profit rather than address actual health needs.

Simultaneously, these bodies are asked to wait. Wait for recognition. Wait for care. Wait for shame. Wait for reparation. Wait for equality. Wait for reform. Across decolonial theory, this demand for waiting *patiently* is regarded as a tool of temporal domination (Maphosa, T. T., & Makama, R. 2025). Those already subjected to harm are expected to absorb ongoing injury in the name of the dominant group's needs and development. Care is endlessly deferred while institutions frame themselves as still learning, not having enough resources, and/or offering containment. In this way, suffering is stretched across time, and the marginalized bodymind becomes responsible for tolerating the pace at which oppressive systems decide to acknowledge it.

The market-driven valuation of health transforms vulnerability into a commodity, where care is rationed according to profitability and perceived economic potential. Consequently, medical institutions become gatekeepers of a horrific calculus: the more a person's condition threatens to disrupt the flow of capital—by rendering them "unproductive"—the more likely they are to face neglect, exclusion, or coercive isolation. This reinforces a capitalist hierarchy that values individuals primarily for their ability to contribute economically, while simultaneously erasing the complex realities of lived bodily experience. Disability, illness, and suffering thus become not only personal challenges but structural tools of exclusion, serving to uphold the capitalist order by policing which bodies are deemed valuable and which are disposable. Insurance companies and licensing boards further entrench this logic by ongoing demands for surveillance and risk management.

Unspoken Prisons

In the 17th and 18th centuries, people who presently might qualify as mentally ill were often integrated within their families, communities, and religious institutions. By the 17th century, this situation changed dramatically. Foucault (1961) described this period as the beginning of the "Great Confinement:" state organization of those considered unruly, dependent, or unproductive and consequent labeling of them as mad. Madness became framed as a moral failing, a lack of reason, and a threat to social order.

Workhouses, poorhouses, and prisons confined mentally ill people alongside others deemed socially undesirable. As Europe moved into the Enlightenment and its ideals of reason, science, and progress, what was understood as madness was further reshaped. Paradoxically, the Enlightenment's emphasis on rationality sharpened the split between the rational and irrational, normal and abnormal, productive and dependent.

It was also during this period that the foundations of modern psychiatry began to emerge. Physicians increasingly claimed authority over madness, replacing moral and religious explanations with natural and medical ones. Yet the medicalization of madness was never separate from discipline, obedience, and social control. Treatment emphasized routine, labor, surveillance, and behavioral conformity while and presenting itself as "humane" compared to the chains and bars used in prisons. Surveillance was presented as care and recovery was only achievable through obedience, self-regulation, and compliance with institutional norms.

The few asylums that existed were overcrowded, prison-like, and tightly controlled. Patients often shared dormitory-style rooms, ate basic meals, and were prescribed labor or

exercise as therapy. Some asylums even allowed paying visitors to observe patients as public spectacles, transforming madness into entertainment rather than recognizing it as human suffering. Madness increasingly became a tool through which societies disciplined those who did not conform to dominant ideals of reason, morality, and productivity (Whitaker, 2010).

These histories continue to shape contemporary understandings of disability and mental illness. Definitions of sanity are still built upon theories of the self—particularly the ideal of a singular, coherent, rational self that is legible to authority. These frameworks rely upon normative temporality and normative productivity, punishing those who do not, cannot, or are not allowed to conform to settler colonial expectations of behavior and independence. Historically, labels of insanity have been used to discredit marginalized people, dismiss their lived experiences, and justify "treatment" in the name of care. By framing certain ways of existing as inherently invalid, lived experience becomes suspect while institutional and medical authority are elevated as objective truth.

Critical disability and mad studies frameworks help us understand that concepts such as mental illness and wellness did not develop in isolation. They emerged alongside broader systems of colonialism, empire, racism, capitalism, and neoliberalism—systems that determined whose bodyminds would qualify as rational, productive, trustworthy, and fully human. Because disability is framed as abnormal and undesirable, it becomes permissible to intervene—even violently—so long as the intervention is framed as therapeutic or curative (Steele, 2018). Psychiatric hospitalization programs, for example, are positioned as sites of protection and care for those considered dangerous to themselves or others due to mental illness. Yet the "care" these institutions provide frequently operates through coercion, segregation, surveillance, and the denial of self-determination. Many people who leave psychiatric institutions report heightened

trauma resulting from restrictive environments, toxic living conditions, lack of affirming care, and experiences of dehumanization (Ben-Moshe, 2020).

The presiding and policing nature of mental health institutions produces restrictive, correctional, and often violent effects upon disabled bodyminds. Institutions such as psychiatric hospitals, group homes, special education programs, nursing homes, and mental health facilities operate through carceral logics and should therefore be understood as such (Steele, 2018). Within these spaces, disabled bodyminds are pathologized, surveilled, assessed, and "attended to" under tightly controlled conditions that ultimately justify further intervention and restriction.

Psychological assessments themselves participate in this process by locating deficits within individuals and assigning levels of severity based upon perceived failures. The greater the number of reported deficits, the greater the level of monitoring, intervention, and institutional control imposed upon the bodymind. I use the word "imposed" intentionally here because these bodyminds are so often denied autonomy within processes of surveillance, assessment, and treatment. Their devaluation renders them less fully human and therefore less trustworthy as authorities over their own lives (Babbar, 2025).

These dynamics also intersect with ethical codes and licensing laws within clinical practice. Mandated reporting laws are framed as mechanisms for protecting vulnerable individuals, but they also operate as systems of surveillance and liability management that may ultimately protect institutions and clinicians more than the individuals themselves. Clinical practice frequently utilizes the rhetoric of care in ways that profit from suffering bodyminds. Crisis management protocols, psychiatric holds, safety planning, foster care institutions, and nursing homes all function through systems that prolong treatment, generate additional trauma

requiring further intervention, and manage institutional risk in ways that stabilize professional and financial structures.

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