RESISTING "GOOD IMPERIALISM": READING DISABILITY AS RADICAL VULNERABILITY

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During a recent conference on "Generations of Feminism" in Chicago, Gayatri Spivak critiqued western feminists' tendency to impose their own cultural biases upon women's issues in non-western countries, arguing that any meaningful assistance must emerge from an understanding of the language, customs, and historical context of the cultures involved. Otherwise, Spivak said, we are simply replacing "bad imperialism" with "good imperialism." At the time, it struck me that "good imperialism" provided an apt designation for much of the charity work peddled to westerners for the sake of improving the lives of people in underdeveloped regions. I am specifically interested in exploring how disability and its eradication figure prominently in such "benevolent" projects, and want to suggest certain methods disability studies scholarship might use to critically challenge the ways impairment, aesthetic difference, and other forms of social disability are foregrounded to mobilize "ethical" interventions from the West. This article considers one non-profit organization's mission of providing surgeries for cleft lip and palate in an effort to provide a framework for reading disability more widely within postcolonial contexts.

For some scholars committed to challenging discriminatory and oppressive practices upon people with disabilities, postcolonial theory has offered a perspective from which to theorize the marginalized position of disability in contemporary Euro-American cultures. Arthur Frank, for example, explains illness and disability as "medical colonization" in that modern medicine lays claim to the patient's body as its own territory. However, while this parallel is productive to thinking about disability in developed nations, such theorizing also runs the danger of effacing the very real differences between the social understandings and lived experience of disability in specific non-western contexts from those driven by medical models in the West. In order to avoid projecting a globalizing concept of disability that might mask the culturally specific issues of disability it seeks to

understand, following Cindy LaCom, this article explores the complicated terrain of reading the *disabled colonized* body. Like her, I ask how such bodies fit into the "dialectic between colonizer and colonized and into the transaction of the post-colonial world" (139). So, rather than asking how the social positioning of disability in highly developed cultures mirrors the oppressive context of colonialism, I am suggesting that the articulation of disability by the West upon the bodies of "Third World" others often perpetuates and participates in projects of good imperialism.

In the familiar guise of charity and benevolent liberalism, disability marks an essentialized vulnerability which functions as the representative borderline between the limitless potentialities of the "First World" sharply contrasted with the inevitable suffering and limited existence available in "Third World" contexts. Within this problematic binary, vulnerability functions discursively to perpetuate an artificial and monolithic First-Third World divide. I am interested in deciphering the meaning of western dependency upon this discursive deployment of disability, not only in terms of defining non-western others, but in the continued construction of U.S. national identity in terms of the purifying eradication of physiological and aesthetic difference. From a disability studies perspective, I am suggesting a transgressive reading of vulnerability which not only critiques these discursive practices, but also understands vulnerability as a radical element in forging cross-identity, cross-cultural alliances committed to exposing and interrogating the ways western values become inscribed upon the bodies of "Third World" subjects.

Margrit Shildrick's insightful work on western constructions of "monstrous bodies" is grounded upon an understanding of vulnerability germane to this notion of a transgressive reading of disability. Shildrick points out that bodies designated as monstrous reflect a threatening opposition to the paradigms of human corporeality "marked by self-possession" (5). In order to claim the security of individual identity, the monstrous is rejected and held forth to exemplify that which is not the self. However, following the logic of deconstruction, "at the very moment of [self] definition, the subject is marked by its excluded other" (5). In other words, the excluded other is at the very heart of the self; it is both projected out and dwelling within. The western ideals of the sovereign self or the contained body, then, depend upon an exclusion of corporeal vulnerability, but as Shildrick points out, this exclusion is actually always incomplete. She argues instead that anomalous bodies designated as monstrous—often those with disabilities—actually reflect a vulnerability inherent in all of us:

> In the encounter with the disabled or damaged body, the shock is not that of the unknown or unfamiliar, but rather of the psychic evocation of a primal lack of unity as the condition of all. But as something unacknowledged and unacknowledgable, that vulnerability is projected onto the other, who must then be avoided for fear of contamination. ("Becoming Vulnerable" 224)

While most of us would readily admit our bodies are vulnerable—to disease, illness, infection, accident, or other alteration—corporeal vulnerability is still largely seen as weakness. Medical discourse intercedes at this juncture, attempting to shore up the inevitable (yet effaced) vulnerabilities of bodies with strategies of prevention and cure, and disability is often the featured representative trope within the borders between excluded other and successful medical intervention. In this sense, disability itself is a highly disruptive discursive element. If we think of disability in terms of radical vulnerability, we insist not only upon a critical reading of the figure presented as innately vulnerable, but more importantly, upon exposing the concealed fears and desires mirrored by the discursive drive to exclude, efface, or eradicate.

In order to further discuss the problematic intersections between medical discourse, the postcolonial body, and disability, I want to refer to a mainstream advertisement for a non-profit organization called the Smile Train—which draws heavily upon troubling assumptions about "First" and "Third World" divisions. The full-page, color, advertisement described below was positioned within the cover story in a recent issue of *Newsweek* (April 7, 2004) in the U.S. Similar ads, often featuring photos of different infants and children, are regularly featured in other mainstream newsweeklies and popular magazines. Visually, the advertisement features two photographs of the same child, one before and one after a surgical procedure to correct the child's cleft lip and palate. Following in the tradition of Edward Said, rather than attempt to unearth the hidden meaning of the images, I want to explore the discursive authority on the surface, to expose, in his words, "its exteriority to what it describes" (20). Said taught us that colonial representations reveal far more about the colonizer than the colonized. With this in mind, the advertisement, while projecting vivid portraits of an aesthetically marked infant, reveals more about the imposition of western moral and medical authority than it does the desires of the child. The child itself—who remains nameless, raceless (although dark-skinned), nationless, and genderless—is apparent but unheard. In fact, the effectiveness of the advertisement depends on the child's silence and transparency. In other words, these striking "before and after" images provide the blank surface upon which the western "ad copy" can be inscribed. Said explained why such

a process of silencing must occur: it is the western observer who "makes the Orient speak," who "renders its mysteries plain for and to the West." Orientalism as a system of discursive representation reflects western hegemonic constructions of "Orientals, their race, character, culture, history, traditions, society, and possibilities" (20-1). In much the same way, many current western constructions of Third World subjects attempt to perpetuate this problematic endeavor.

The text of the advertisement, for example, attempts to evoke a sense of immanent tragedy and suffering that can only be ameliorated through an immediate response by western charity. A large, bold lettered headline provides a simple admonishment to readers: "Give A Child With A Cleft A Second Chance At Life." Beneath this appeal sit the two images of the same smiling child, the second (post-operative) image apparently representative of a child now ready to embark upon the "second chance" promised by the organization. The rhetoric of this promise is especially telling in the fine print: "Today, millions of children in developing countries are suffering with cleft lip and palate. Condemned to a lifetime of malnutrition, shame and isolation." Further along, we see that these children come from all parts of the world, but readers are still presented with a troubling truism: regardless of individual cultural differences, the universal response to disability and aesthetic difference of cleft lip in developing countries is represented as absolute social rejection.

The tragic inevitability of suffering by such children is further described on the organization's website, but again, cultural specifics are replaced with essentialized stories of isolation and despair. Children with cleft lip and palate are described as suffering a "long nightmare," enduring "lives [that] will never be lived." And regardless of whether the child is born in Asia, Africa, South America, Russia, or other areas, Smile Train newsletters bear witness to a global fate: "they will suffer their entire lives in silence as the world looks the other way. Trying to survive in a society that pretends they don't exist." Ironically, the silencing that Smile Train purportedly ameliorates is actually reinstantiated through its own marketing materials. Even more troubling, the ubiquitous "society" of the developing world is discursively sewn together by the presence—and suggested prevalence—of disability, as well as by its shared aversion and rejection of the innocent victims "suffering with cleft lip and palate." By focusing upon cleft lip, a difference which is widely corrected in the United States (although within the deeper layers of their literature, this organization admits to providing resources to poorer families in the U.S. as well), the Smile Train organization presents the prevalence of disability as evidence of developing nations' immeasurable lack—lack

of resources, technology, and more insidiously, of understanding. In this way, the First and Third World divisions are re-solidified, and "we" of the overdeveloped nations are positioned as superior—with greater economic power, medical knowledge, and even compassion. This division impedes the formation of partnerships between groups of disabled people within highly developed and underdeveloped nations. The "tragedy" and "suffering" of these children is displaced upon a falsely unified "society" of developing nations, which allows western readers of the advertisement to understand these undifferentiated cultures as cruel or less advanced—as atavistic versions of our own culture in need of our paternalistic guidance. As Susan Wendell has warned, the desire to eliminate differences that might be feared, misunderstood, or seen as signs of inferior status often "masquerades as the compassionate desire to prevent or stop suffering" (156). In effect, Smile Train packages these children and the societies that have isolated and abandoned them without treatment as those in need while American readers, especially those who offer donations, are congratulated as benevolent providers. Within this rubric, disability, an essentialized trope of dependency, provides evidence to perpetuate the long-standing paternalistic hierarchy between underdeveloped and overdeveloped nations, and also serves as a foil to the actual western desire of erasing differences that exceed the perceived boundaries of "normal" corporeality.

Further, the charity's decision to focus upon the erasure of cleft lip and palate has specific racial underpinnings which should not be overlooked. Troy Duster's examination of contemporary genetic screening procedures illustrates how a discourse which presents itself as neutral, scientific, and beneficial towards health can subtly reinforce oppressive attitudes about race, ethnicity, and disability. Duster notes that cleft palate has a higher incidence among Japanese people and North American Indians, arguing that public health responses to such conditions are often underpinned by political, social, and scientific discourses which introduce what he calls "eugenics by the back door" (114). Using Duster's framework, it could be argued that the whole desire to rid ourselves of cleft lip and palate is itself a thoroughly Orientalist project because this condition occurs disproportionately in non-white ethnic groups. However, the medicalized discourse of public health responses including those organized by charities such as the Smile Train elides their own racism and ableism. In this advertisement, Smile Train uses the additional discourse of pleasure—after all, who could be opposed to the fulfillment of happiness represented by a smile? Of course, in asserting that the second image represents the only real smile, the advertisement effaces the

fact that people with cleft palate can and do smile—as the first image clearly demonstrates.

Abby Wilkerson's research into the moral authority of medicine draws from Foucault to point out that modern medical discourse introduced the concepts of the objective, detached medical gaze to solidify its own discursive influence:

> In this epistemic process, medicine acquires the status of cultural healer, a purity that is epistemically rather than religiously or spiritually certified, and that helps to resolve society's deep ambivalence toward science and technology, so frequently perceived as out of control. Based on this epistemic certification, medicine serves as the locus of ritual for creating, maintaining, and restoring social order. (63)

Objective detachment provided medicine with an invisible subjectivity, which has been translated to a profound authority that has only increased over time. In contrast to the religious and cultural colonization practiced by imperialist nations in the nineteenth and twentieth centuries, medicine and technology provide a powerful ethical authority to what might be called postmodern missionary projects. If local cultures accept and adopt "our" technology and commit themselves to the erasure of cleft lip, they prove themselves to be "progressive" and "forward-thinking." Within Smile Train's literature, there is no suggestion that local responses to the health issues of cleft lip and palate are in place. The tacit assumption is that without intervention from western charity organizations to teach this surgical procedure to local doctors, thereby "empowering" them to respond to the issue appropriately—in other words, to respond with "corrective" surgery as doctors in the West have been trained to do—their children will be condemned to social death.

The discursive implication is that medical erasure of the cleft promises also to seamlessly erase the social issues connected to shame and isolation without having to address them directly. Not only is disability rehabilitated, but the troubling social reality accompanying aesthetic difference is putatively solved as well through the power of medical technology. In its promise to offer a "second chance" to individual children through surgical procedures, the Smile Train also suggests a rehabilitative strategy for cultural advancement: regardless of local understanding of disability, cleft palate, and local health systems, advancement always follows the trajectory of western knowledge.

More powerful than the textual arguments made by the advertisement are the double images of the infant's face which attempt to package "hope" and "possibility" in aesthetic adjustment. The child's

body becomes the biopolitical terrain upon which the West attempts to construct vulnerability in terms it can manage. While individual bodies resist absolute definition, the aesthetic marker of disability discursively suggests the child's smile as the negotiating surface upon which global inequities will be rectified. In a sweeping gesture, economic imbalances, poverty, national tensions, unequal access to knowledge and technology, and myriad other social issues are projected onto one malleable bodily surface. These larger—and arguably more pressing—problems become tacitly contained within the rehabilitated smile in the second image. In this process, the surgical erasure of the cleft lip becomes highly symbolic of western charity's attempt to mask broad-scale inequities through medical production of aesthetically standardized smiles.

Abby Wilkerson points out that the framework of liberalism often fails to understand illness, disease or disability within the social milieu in which they reside: "liberal theorists often overlook the material circumstances that constrain these [medical] choices for oppressed groups, and that strongly influence their physical and emotional health and well-being" (112). She argues that we must move beyond dichotomous thinking which attempts to split the "natural" experience of the human organism from the "social" order. Instead, Wilkerson favors a "material-semiotic" approach to health disparity, which takes into account the social, economic, and prejudicial forces facing individuals and groups in their access to medical services. While Wilkerson is looking primarily at oppressed groups in western societies, her insights are useful to this discussion. The Smile Train organization actually writes extensively about the deplorable economic conditions most of these children live in, but the literature superficially suggests that the medical miracle of surgery for cleft lip and palate will provide the child with all the resources he or she needs to compete equally with other children in the region. One story on the organization's website features Aira Hernandez, a Filipino girl born in 2001. Her family lives next to a garbage dump, where her father works to scavenge food and clothing for his wife and children, struggling to pay five dollars rent every month. Through a social worker, Aira was enrolled in the Smile Train program, and received the free surgery. According to their newsletter, her family's reaction is grateful relief for a "dream come true": "This is her chance to be normal and to go to school…We were so worried about what would become of her, but now we know she will be okay" (online newsletter 4.1). While the poverty of Aira's family is profound, it is only highlighted to explain their inability to afford the cleft surgery, and Smile Train implies that with hard work, now that Aira has been medically restored to normalcy, her whole

family will be better equipped to surmount the socio-economic barriers ahead of them.

Such displacement of social and material forces onto bodily surfaces calls into relief the interplay of power between individual subjectivity and the political structures of objective definition. In some of Foucault's later writings, he focuses his analysis of power upon the tension between *political techniques*—processes by which the state assumes the care of individuals—and *technologies of the self*—processes of subjectivization which allow the individual to define his/her own identity and also attach this identity to an external authority. Georgio Agamben frames Foucault's argument as follows:

> "[T]he modern Western state has integrated techniques of subjective individualization with procedures of objective totalization to an unprecedented degree, and [Foucault] speaks of a real 'double bind,' constituted by individualization and the simultaneous totalization of structures of modern power." (5)

Modernity's problematic "double-bind" might be useful in considering the interplay between the modern western state and its totalizing definition of disability and the subjectivity of the very specific yet unnamed child. Because of the cleft lip and palate and the unique resources this child is said to demand, he or she is projected to the western readership in a state of hyper-individuality, and yet the very source of this unique subjectivity is the facial difference that has already been removed. As Rosemarie Garland Thomson has argued, the hypervisibility of certain disabled people (such as this child) can only occur in a wider context of the cultural invisibility of disabled people in general. Further, the individuality that disability provides also represents the totalizing objectification enacted by the Smile Train organization upon the body of this manifestly anonymous infant. To the charity organization, the child represents the tragedy of disability interrupted by the benevolent wisdom of western medicine. The "double-bind," in this case, is not so much this child's subjectivity in relation to totalizing power, but the problematic projection of individual subjectivity onto an unknown and unknowable body.

In her seminal essay, "Can the Subaltern Speak?" Gayatri Spivak argues that because the western understanding of subaltern voices—especially those of women—is inevitably based upon projections of an interior voice from the West, the subaltern, in effect, cannot speak. Furthermore, the West's need to solidify itself as benevolent provider and ethical leader demands that subaltern subjects be represented as fundamentally at odds with their own cultures. After all, in order to provide, the West must establish an urgent need that is not being met locally. As Spivak states, "Imperialism's image as the establisher of

the good society is marked by the espousal of the woman as *object* of protection from her own kind" (299). Similarly, the implication of Smile Train's interventions is that the fate of these children cannot be entrusted to their own families, villages, and societies, but that their very survival depends upon an immediate western response. In other words, western ethical subjectivity continues to depend upon a voiceless subaltern, and the voicelessness, in turn, is dependent upon the assumed vulnerability of culturally dislocated disability.

My intention is not to assert that all western medical interventions are inherently wrong. Many of these children and families appreciate and benefit from the free surgeries offered by Smile Train. However, I am arguing that western scholars have a responsibility to interrogate the imposition of culturally specific values upon non-western cultures, especially the exploitation of disabled bodies in the marketing of good imperialism. Abby Wilkerson reminds us that our well-resourced, western conception of illness, disability, or disease as elements dwelling outside the realm of the ordinary is actually a very privileged perspective, and while western scholars often cite our own privilege, we must vigilantly guard against subtle practices of perpetuating the very problems we critique. I want to suggest that disability studies scholars, in particular, might reach across cultural boundaries to gain more insight about the different meanings of disability in specific locations in order to provide a counter-narrative to the potentially monolithic western discourse of medical (social) rehabilitation.

As the child in the Smile Train advertisement clearly illustrates, the disabled body functions as a powerful discursive site upon which various anxieties are projected and where wider cultural, social and political interests battle for hegemony. The "radical vulnerability" of disabled bodies has the potential to be read in two directions—across the surface of the image into the reflected desires and motivations behind the broader hegemonic projects. In this small example, we have seen hegemonic concerns over such wide-ranging issues as aesthetics, embodiment, medical and technological "progress," cultural differences, the personal and political, economic development, and globalization. Such anxieties and projections demonstrate the importance of a fuller engagement between disability studies and postcolonial theory in order to challenge the continued production of Third World disability for First World consumption.

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