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A culture of silence: Modes of objectification and the silencing of disabled bodies

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Throughout history different practices have attempted to silence the experiences of disabled people. In this paper we explore some of these practices including the medical, familial, and self-subjugating practices English-speaking Canadian polio survivors experienced throughout their lives. We analyze participant's experiences of silence and silencing through a Foucauldian lens, drawing on the three modes of objectification to explain the institutional and cultural discourses around polio subjects that acted upon and through the polio body to silence it. Participants' oral history accounts demonstrate how sociocultural and medical practices effectively silenced survivors from speaking about their polio experiences. However, the trope of silence is also uprooted within oral history traditions (Portelli, 2006). We will demonstrate how participants broke their silence and shifted their perspectives on polio and disability, and how this process contributed to their resistance of hegemonic conceptualizations of disability as defective.

Keywords: disability; silence; enmeshment (enfleshed); oral history; modes of objectification; Polio

Four Points:

- Oral histories of people who contracted Polio in Canada prior to 1955 demonstrates how people would not speak about their polio and would hide its effects growing up (silence)
- We show how this silence around polio was maintained by medical treatment (e.g. isolation), family practices (e.g. not saying the word polio), and by the individuals themselves (e.g. disguising parts of the body that had polio).
- Participants, however, broke the silence around their Polio especially when they needed accommodations at work.
- Exposing silences among marginalized communities may facilitate collective action and social change.

Silences exist in the historical record of the disability community. These silences are also evident within the everyday lived experiences of people with disabilities and were present in stories shared by Canadian polio survivors in oral life history interviews. Silence is used throughout this paper to explain three different conceptualizations. First, silence is used as a motif to demonstrate the absence of disabled people's experiences throughout history (Chenoweth 1996). Second, it is used to illustrate realities for many disabled people who are silenced from speaking about their experiences of living with polio. Third, as a theoretical lens, silence is used as a way to investigate and explain the self-silencing and different self-technologies participants in this project performed on themselves with the intent on passing as non-disabled (Campbell 2008).

We dialogically interact with various theorists' conceptions of silence; self-subjectification and disability, in order to better articulate the complexities of participant's experiences throughout their lives. A culture of silence was first discussed by Paulo Freire (1970) in his "The Pedagogy of the Oppressed" and his introduction of the 'myth'; where the oppressed, overwhelmed by the values and norms propagated and enforced by oppressors, are silenced. Freire argues that the myth becomes internalized – naturalized – disregarding the experiences of the oppressed, creating a hierarchy of knowledge, truth, experiences and persons. Freire's conceptualization of silence has been applied to explain the silences within various marginalized communities such as women who have experienced violence, people with disabilities, and institutionalized people (Chenoweth 1995; Chenoweth 1996).

Foucault discusses the notion of silence in Volume 1 of *The History of Sexuality*:

There is not one but many silences, and they are an integral part of the strategies that underlie and permeate discourses (1978, p. 27).

Similar to Freire, Foucault argues that silence is a strategy that is foundational to the production of discourses. Foucault's argument allows for the possibility of multiple silences that work together in subjugating individuals. Discourses around normalization produce subjugated individuals who act upon themselves, performing technologies of the self in various ways to 'silence' themselves. We are using the concept to represent the social and cultural discourses around polio in the 1940s and 1950s in Canada that rejected and attempted to normalize disabled identities; all the while silencing participants lived realities.

Foucauldian notions of the body: Bringing lived bodies back into the discussion

Central to Foucault's collective work is the idea that circulating discourses produce and govern 'the subject' bodies. Discourses produce not only bodies subjected to external control, but also self-regulation. These 'docile bodies' conform to dominant normative standards of the body (Foucault 1978).

Hughes (2005), discussing Foucault's concepts, suggests this external process can be conceptualized as three modes of objectification that provide a means to understand how certain types of 'subjects' are constituted through discourse. The three modes are: 1) practices of designation; 2) dividing practices; and, 3) practices of self-subjectification. Self-subjugating practices can be understood as 'technologies of the self'.

According to Foucault (2003),

Technologies of the self, which 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 (p. 146).

Many scholars, including Hughes (2005), have argued that Foucault's conception of the body as passive – subjected to others and self-subjecting – while limited, is important to the discussion of practices that constitute and regulate disability. Foucault's docile body is a way of explaining the processes by which people come to know a naturalized truth of the body, the normalized socio-cultural practices around the body, and how people act upon and ascribe technologies on themselves. However, from our stance, Foucault's notion of the docile body is limited as it treats the body as singular and uniform – devoid of experiences. Our perspective is that there are multiple and diverse bodies that interact within various social, cultural, and historical contexts. .

Contemporary body theorists have advocated for bringing bodies back into the discussion (Zola 1991). Many authors have suggested it is important to include meaning and experiences of bodily realities within a broader social context. The concept of embodiment is used to capture the relationship between individual and society, and body and culture. Williams and Bendalow (1998) believe that embodiment provides a way to understand lived bodies as a fluid entity and a contextual materiality.

Critical theorists of education have also theorized beyond cultural inscriptions to the 'being of body'. Ervelles (2000) takes up McLaren's notion of enfleshment as how bodies are inscribed by the dominant cultural practices of schools. Ervelles (2000) emphasizes Peter McLaren's point that to be enfleshed, 'is to be marked by discourses that not only sit on the surface of the flesh but are, on the other hand, embedded in the flesh such that we learn a way of being in our bodies...that is we are taught [how] to think about our bodies and how to experience our bodies' (33). McLaren's enfleshment is a form of embodiment that brings together bodies and culture within a normative space (i.e.

education) and delves into how bodily experiences can be shaped by culture. However, this view of enfleshment also suggests how bodies can influence or shape culture. We take up McLaren's conception of enfleshment as we propose a dialectical relationship between bodies and culture(s), which provides the foundation for resistance. Foucault (1978) emphasizes that circulating discourses could produce fluctuating systems of power that makes resistance possible. According to Foucault, individuals are always inside a network of hegemonic power/knowledge regardless of whether they are conforming to and/or resisting dominant discourses that construct their bodies and subjectivities. However, our reflexive and dialectical nature of embodiment-enfleshment, allows for dominant power/knowledge to be circumvented, or put aside by the actions or agency of individuals within dominant structures, processes, and contexts.

In this paper we discuss the modes of objectification and technologies of the self and incorporate notions of embodiment-enfleshment to understand the constitution and meaning of silence around polio in the lives of Canadians who contracted polio prior to 1955. We use the three modes of objectification as a means to illustrate how Canadians who contracted polio were transformed into 'polio subjects'.

Methods

We developed silence as an overarching theme from our analysis of participant's experiences of living with polio, such as exclusion within school, at their place of employment and in with various interactions with family and friends. ¹ We conducted 36

¹ This paper is part of a larger academic-community research project that focuses on documenting the oral life histories – including participant's activist work and experiences – of Canadians who contracted polio prior to 1955.

interviews with English-speaking Canadian polio survivors: 13 identified as male; 23 identified as female, and within this, four participants identified as people of colour.

Specific boundaries for individuals to be included in this study were that the person: 1) contracted polio between 1927 and 1955; 2) lived in Ontario, Alberta or Manitoba during this time period; 2) was less than 30 years of age when s/he contracted polio; and, 3) used assistive devices during/since this time. Epidemiological data indicates that these provinces and this 28-year time period had the highest number of reported polio cases in Canada (Rutty 1995). We expanded our recruitment sites to Northern Ontario and Nova Scotia to include rural and geographically diverse experiences of disability. We conducted video and/or audio interviews with the participants, lasting 2 to 3 hours. Given the length of these sessions, we asked participants how they wanted their interviews to be organized. For example, some participants split their interviews into two sessions, either on the same day (morning and afternoon) or on different days.

Participants' oral life narratives shed light on their experiences from the 1930s up to today. Their experiences of silence and silencing took place in various spaces throughout their lives. This culture of silence was epitomized by many of the participants stating that they had not spoken about much of their lives growing up with polio and in a very few instances, participants had not spoken to anyone at all about their polio. This notion of silence was pervasive throughout the study and emerged from our analysis.

Knowing this, we actively encouraged the participants in telling their stories. We stressed that their lived experiences were an important and integral part of Canadian polio history that has not yet been documented. It was clear as the participants talked about growing up with polio, that they had thought about it a great deal. Most participants were

reflective about their stories and experiences, drawing connections between life events, exploring fundamental social and cultural changes throughout their lives, and in sharing their experiences, reconstructing their histories, while deconstructing the silence around their polio experiences.

Culture of Silence: Stories of growing up with Polio

In the following three sections, we analyze participant's experiences of silence and silencing through a Foucauldian lens, drawing on his three modes of objectification to explain the institutional and cultural discourses around polio subjects that acted upon and through the polio body to silence it. In the first and second sections we discuss the process of designation and practices of division that occurred in both the hospital and home (following participants return from rehabilitation centres or hospitals), respectively. In the third section, we discuss practices of self-subjectification that participants experienced throughout their lives, capitulating to normalized subjectivity, often rendering their disabled bodies silent and silenced. However, we also discuss their resistance to these practices, shedding light on the instability of normalizing discourses when bodies are rendered whole and complicit.

Becoming 'Polios'

Participants were quickly removed from their parents after learning they had polio. They were isolated or quarantined and medically designated as sick, contagious, and 'polios'. When placed in the hospital, under stringent medical control, participants experienced a loss of ownership and a silencing of their bodies. Foucault calls this process bio-power, and the first mode of objectification – designation – includes various

disciplinary forces that act upon this newly disabled body, rendering the individual a subject to medical and rehabilitative practices.

Sullivan (2005) writes about the medicalization of individuals with paraplegia: ‘the paralyzed body inserted into – that becomes part of – the medical (and rehabilitative) discourse on paraplegia that maintains the person as a particular subject...’ (30). The experiences of survivors of polio are similar. A polio diagnosis constituted a medical response comprising of isolation, and various treatments, i.e. iron lungs, surgery and physical rehabilitation. Objectivised as sick, designated as ‘polios’, individuals embodied experiences were ignored in order for essential medical practices to take place – initiating the culture of silence participants would experience throughout their lives. Wanda, for example spoke about doctors and hospital staff working on stretching her muscles out even though she often screamed through the process:

I guess he probably had said, ‘Get her walking. Those limbs work. Get them walking.’ They’d get them doing it; probably under the water I’d be stretched. And I can remember having visitors coming in there. And I’d just - I’d scream and they would yell at me to stop that. You know. I REALLY remember that. [...] It was very painful, and I would be screaming. And part of me would probably be ‘Damn you anyway.’

The first practice of designation was naming it polio; the second practice of designation was isolating participants, separating them from family and friends for long periods of time. Isolation is a medical practice associated with prevention, but it is often a fearful and lonely experience as Sandra describes her experience when she was young:

I only saw my mother once every few months she would come. And my grandparents came down a couple of times. But it was ... it was a lonely time for me. And I just lost my father too, you know. So it was ... When my mother would come I would just cling to her. And then ... See I can’t even talk about it. (crying) When she would leave, I just ... just thought the world would come to an

end. It nearly killed me. So here I am all these years later, and I still can't talk about it without getting emotional.

The length in isolation varied considerably among the polio survivors we interviewed ranging from a few days to weeks and months. Stories were shared about visiting parents communicating through doorways or from outside hospitals through open windows. In addition to not being able to see each other close up or often, children were prevented from touching their parents and vice-versa. All of this contributed to the silencing of their experiences as visits were limited to a few hours scheduled far apart from each other. Participants recounted, early on in their recovery, of long hours of silence lying still in hospital beds waiting to be washed, fed, and helped to the bathroom. Some participants, during their time in the hospital, experienced intense and prolonged loneliness; which may have contributed to the silencing of their bodies, and in many cases their experiences. The designation as 'polios' resulted in the subjugation of the body and silencing of individuals.

Disabled bodies were further silenced through the second mode of objectification: division. Foucault argues that a subject is produced by creating docility through the division of the body into parts (Sullivan 2010, 35). In the case of polio survivors, bodies were divided by treating the disabled parts, such as dropped feet, paralyzed limbs, and infected lungs (respiratory issues), and ignoring the body/person as a whole. Participants' bodies were thus subject to refinement, to the perceived responsibilities of normalized bodies; and a lack of mobility was corrected through surgical procedures.

Surgical or rehabilitative remedies were not discussed with participants. As children, they have very little ownership over their bodies and decisions about treatment and surgery

where often left to the parents or guardians. In most cases, participants had to endure multiple surgeries over several years, many of which failed. Lynn describes her surgical experiences at Sick Kids Hospital in Toronto over a 10-year period:

I had umpteen surgeries, I can't even count them, at Sick Kids Hospital [...] I don't know what they call it, but he did a ... – they took a wedge shaped piece of bone out of my leg up here, my right leg, and fused it back together again, and then that automatically put my knee back, but it overextended it so it was really bad. Like, you know, it was really overextended. I guess they took too much. And that started to throw my back out, cause then, I see I wasn't ... – I was, you know, even crooked [sic] than I was before. So that was one surgery which I definitely should not have had. But anyway, that was ... But I was in and out of there until I was about 18 or 19, in and out; in and out of Sick Kids Hospital. Yeah.

'Medicine' – in all its forms – had promised to return participants bodies back to their 'non-paralyzed' forms (Sullivan 2005, 39). Surgeries could involve the fusing of ankles joints, and fusing vertebra in the spine; rehabilitative practices included intense massage therapy, the use of hot (sometimes burning) wool towels (thought to relax muscles that were very tight), stretching exercises (often painful), rubbing of various ointments and other concoctions (such as horse serum and cocoa butter) and a variety of household treatments thought to turn back the paralyzing and weakening effects of polio. Corrective surgeries were not only performed on paralyzed or disabled limbs but as Ann shared, her non-disabled leg was surgically stapled to prevent further growth so as to appear equally balanced with the shorter paralyzed limb. She says:

And then they did a ... a trial operation on me where they were ... put staples in my good leg at the knee to stop the growth so this leg would catch up.

The silencing of the disabled body was intense and persistent, aiming to produce 'healthy' children and adults, and perpetuating the appearance of normalized bodies.

'Bad leg' and 'shrivelled arm' but rarely Polio

Upon returning home, polio survivors and their parents continued the designating and dividing practices that were inscribed onto them at the hospital. Parents became agents of social control by incorporating objectifying practices into daily family life.

With respect to designation, many families did not speak about their child's polio, or rarely mentioned it by name. They often referred to it as the 'child's condition', 'bad leg', 'shrivelled arm', but rarely as polio. Marc Shell (2005), in his book, discusses how silence around polio was an unspoken instruction he received from his parents. He says, 'I followed the parental rule not to mention my polio.' (53). Participants had similar experiences to share. Beth says:

We lived in a small community. And ... there might have been other parents that had children with polio, but we weren't talking to them about what, you know, what they were doing. It was our ... it was our journey. It was as though I was the only person in the world that had this, and they were doing whatever they thought was right.

Wanda also spoke about the silence around polio in her home, saying:

My father ... My parents, you didn't say the word polio. Crippled children. I mean that was something that you didn't say in your house.

Along with not speaking about polio, some participants' remember their parents preventing them from listening to radio advertisements on polio or polio camps. While this may have been done to 'protect' the child, some participants' argued that this reinforced their continued silence around polio and their differences.

Dividing practices were adopted directly in the home. Parents had their children do hospital exercise regimens or attend out-patient therapy to promote movement in paralyzed limbs. Sharon recalls some of these exercises:

Growing up I'm really close to my mom and she's the one- she used to do the exercises that the hospital showed her what to do with me. And it didn't work out well because I used to scream a lot...always hurt because she used to have to put me on the table and pull my leg back. Like stretch my hip and stuff like that. And I used to wrap myself around her somehow. And I would scream.

While some exercise regimens were more discrete, like piano classes so they would use the 'polio' arm, parents continued to promote exercise in all areas of children's lives (e.g. swimming across the lake, walking to school using crutches).

Remembering these events was generally painful. Some participants were very clear about how much they disliked doing exercises. Many of the participants stated in similar ways that they 'had to grin and bear it'. So they were silent and kept doing the exercises – walking, strengthening, stretching, swimming, climbing, etc. Their silence was an embodied silence that many carried with them. Silencing of pain or complaints was required so that patients could focus on treatment and progress along the lines dictated by medical intervention and physical therapy treatments. Spatial arrangement outside of the hospital reinforced the notion to meet the demands of an ableist world. Participants were encouraged to walk to school, walk up the stairs, and play sports and participate in gym, which reinforced the silencing of bodies outside of medical spaces and treatments in the home.

Participants were discouraged from discussing their experiences of polio; including any pain or discomfort they were feeling. Family members would often point out to participants that they were 'the lucky ones' having survived polio; in effect further silencing participants from discussing the difficulties of having polio (Wilson, 2005). These sentiments were conveyed to them in the hospital and in the community. Sam remembered these sentiments being shared with him as a child:

[...] The other thing that I was told at a very young age that really resonated with me is I was told I was one of the lucky ones. So if you're one of the lucky ones you don't have the right to complain, and whine. So I grew up ... believing that crying was a sign of weakness.

Gwendolyn said this about seeing other polio survivors:

You go along with it because there's no way really ... Like get pills when the pain is too bad. Sometimes it's there. But ... like I say when I saw some of them, you know, what they [other people with polio] went through I feel in a way that I was lucky to come out this way.

These notions were reinforced in the community, as many participants were often the only polio survivors in their community or in their school. Thus the guilt of surviving polio meant that you had to continue to grin and bear it and get better in silence. Thus, medical/rehabilitation efforts acted as the apparatus of the state to act on subjects – to improve them, make them whole, so that they could contribute to the post WWII political economy of strong and productive families (Strong-Boag 1982).

Families however, tried to mitigate the cultural representation of polio as difference. Parents did not always take up the practices as fully as in the hospital. Many parents knew the limits of the 'overcoming narrative' and some intervened as appropriate in their children's lives. For example, for parents whose children were used to climb stairs to exercise and get to their classrooms, parents advocated for their children to have their classes on the main floor of the school (Yoshida, Shanouda, and Ellis 2013)

However, the push by parents to instil in their children the 'can do anything' mindset contributed to many of the participants pushing themselves physically in ways that seem extreme now, but at the time, illustrated their competency, self-sufficiency and independence. These character traits were necessary for them to get on with their lives and to advocate for themselves.

Meeting/rejecting cultural expectations and owning the ‘big shift’

The practices of designation and division in the sites of hospital and home were deeply inscribed on and within the participants. They learned, in these contexts, how to think about and experience their bodies (McLaren 1998). This enfleshment is important to self-subjectification – the technologies of the self. However, over time and at times, participants were able to shift their thinking from the silence of ignoring, disguising and demanding on their bodies to listening, reflecting on, and responding to their bodies. We articulate this as the ‘big shift’, which, for us, epitomizes a breaking of silence.

Meeting expectations: Ignoring their bodies

The silence about polio was not only verbal, but visual as well. As participants became older, wearing pants (bell bottoms) and longer skirts (maxi skirts) for young women allowed them to further remain silent about their polio as it was out of sight. These practices of concealment kept polio silent, and it also demonstrates the extent of subjugation acted upon by these individuals from their designation as ‘polio’.

Besides the concealing of their polio bodies, participants actively strove or performed as ‘normal’ adults. The technologies of normalization (Tremain 2001) accompanied participants throughout their lives and lead to the acting upon their bodies. One area this was evident is in participants’ accounts of their adult working lives.

Many participants would not ask for any considerations related to their polio in relation to labour force participation. Ann speaks to the strong work ethic of participants and needing to prove to herself and others that she was capable of working as an education assistant:

I ... put a hundred percent into that job and never asked for any favours, or help, or ... when anybody asked me to do anything I didn’t say ‘Oh, I can’t do

that.’ Or ‘Maybe I shouldn’t do that.’ It was ‘Yeah, sure. I’ll do that. I was trying to prove to myself, and everybody else, that I could do it. I was capable of doing the job.’

Another participant, Earl worked very hard as a salesman and avid sportsman. He articulated the same philosophy as Ann. Earl’s ‘all out’ philosophy of life extended into his work and adult life.

I went ... I started to pump iron. And I would pump iron six, seven times a week and just, you know, like everything that I was doing - It seemed that when I went to something I would always go to an extreme. It wouldn’t be like normal one or two day a week thing.

Lynn was determined to go to teacher’s college. She completed the training and was hired by the school board in the urban centre where she was living. As she recalls her first job was not easy, but she just did it:

My first year was not a good year. I was placed in a portable - 50-some children, grade three. Six, seven, or something like that, where real xxx, trouble. And why she [principal] placed me in that class I’ll never know...And I had to take the kids over for washroom breaks, the gym, and whatever; across an icy yard, and I wasn’t very good on my feet.

Rejecting expectations and owning the ‘big shift’

These participants also demonstrated the shift from silence to the embodied acceptance of their polio. This embodied acceptance began from listening to their bodies.

Ann worked in the school for about eight years:

I guess around the eighth year it really got ... – things got bad because I had pushed myself so hard for so long, and now my body was starting to complain a lot. So ... I asked my principal if for the next year, if she could find a position for me that would take me out of the kindergarten class. Because the kindergarten class, you’re on your feet all day long.

While Ann was willing to live up to the expectations of a normative work ethic in the early years, as her body began to change and become painful and tired, she came to reject these normative expectations and asked for accommodations based upon her bodily needs. While all of this helped for a few more years, Ann eventually quit due to other bodily changes and her belief that she could not do the job anymore.

Earl's shift began as his leg was giving out during sports:

[...] when I said I stopped, or the racquetball stopped ... that was a really bad time. That was a time when I felt that my polio was now a factor in my life again. You know before that I considered myself pretty well invincible and being able to do what the heck you wanted to do, when you wanted to do. But this just knocked me down. And all of a sudden I couldn't ... do that stuff. – but my mind was saying 'You can,' but your body says you can't.

Earl's understanding of his polio and his reconciliation with it came about from joining the Polio Society in Alberta. He says:

I got enlightened big time. All of a sudden seeing people - It wasn't just me. Like there was other people in the same boat, and things like that. You know?

Lynn recalls that her growing awareness of changes in her body was evident in the increased aches and pains and loss of stamina she was experiencing. However, she recalls:

I mean it never dawned on me I couldn't do just anything I wanted to do. And I was having problems, aching. My foot was dragging when I would get tired. You know, I was having a lot of problems.

However in moving to a larger school, Lynn had already taken measures to reject the expectations of always walking around school:

I needed to find a job that wasn't ... – I was climbing up and down stairs all the time. I was using a wheelchair in my new position ... when I went to [school], it was a huge library, and a lot of work. I said can I use a wheelchair?

And she [principal] said to me 'I don't care how you do the job as long as you do it.' So then I used the wheelchair at, you know, I walked up stairs, but then I went into the office, I got my wheelchair and from then on I did my job in the wheelchair.

For Lynn, she realized that using a wheelchair, as her main source of mobility was now more helpful to her, instead of walking using crutches all of these years. This shift in thinking was facilitated by a supportive principal and staff and physician.

Vignette: Beth's disguiser

The following vignette illustrates the process of enfleshment and resistance in one participant's life history. Beth decided to enrol in nursing school during the 1960s. She explained that during her enrolment interview concerns were raised about whether or not she would be capable of doing the everyday nursing duties due to her polio. She was only accepted into the school with support from a physician. He provided a solution to the discriminating position that she was going into. Beth says:

And eventually they did accept me ... I went to University Hospital. And prior to that I should just tell you about a very interesting thing. He had been at a conference in the States and said, you know, 'They're doing ... some cosmetic ... work ... for build-ups, so that you can actually get your calf - you could get a cosmetic appliance that can make your calf look the same as your other calf. How do you feel about that?' So I said, 'Well...you know, sure.' So we had casts of both legs; sent it down to wherever these things were made. It was in the States somewhere.

This 'solution' reinforced the embodied silence of her polio. The use of a 'cosmetic appliance' not only masked the polio leg, it further divided it from her. Beth goes on to describe the appliance: and how she wore it to 'pass'.

... how I wore it is I slid it over my foot up to my leg. Then I had to wear a support kind of stocking ... it wasn't really a support stocking, but it was a heavier thing than a nylon. And then nylons over that. The heavier sock kind of

hid the ... the margins. And for most purposes you would not be able to tell that I had an atrophied leg. So I wore that when I went into nurses training. And that's a really an amazing ... disguiser.

For Beth, her polio meant that she felt compelled to silence her polio leg in this way, by creating a relatively 'normal' calf muscle similar to her other leg. Beth called it a disguiser to cover up her polio. Beth wore this cosmetic appliance every day, in every season, for seven years as she worked as a nurse until 1969.

Beth's wearing of the appliance allowed her to disguise her difference as she was taught and shown by others that it was necessary to do so. Practices of designation/division and the process of enfleshment inscribes polio bodies to ignore, be silent and 'grin and bear it'. However, we suggest through these lived experiences within changing contexts of disability, meant that many participants were able to break the silence or resist the cultural inscription on and in their bodies. Beth tells about this moment of beginning resistance:

And I would come home from work ... And I was wearing my polyester uniforms; coming home from work in the bus, and just dying of heat. And I ... I said to [husband], you know 'God.' And he said, 'Why are you wearing that?' I mean I was adding all of that [weight] to my legs. He said, 'You don't need to wear it for me.' And I said, 'Yeah, you're right.' So I stopped wearing it. So I stopped wearing it in the fall of '69. Yeah. So that was my big [shift] (laughing).

In this quote, Beth illustrates how enfleshed she was in her polio subjectivity. Even though it was hot and uncomfortable, she had learnt to forgo or ignore how her body felt to maintain the silence of her defected leg. Her eventual point of resistance came from articulating or listening to her body (i.e. how hot, tired and itchy she felt having to wear the appliance and nylons on hot summer day). Beth articulated her bodily experiences,

and stating it to her husband, allowed her to resist the hegemonic view of her leg as defected and break the silence around her polio.

Beth's experiences and the experiences of the other polio survivors we have described in this paper took place within a particular social and cultural context that affected not only polio survivors but also many other disabled people. Forced institutionalization, long hospital stays, discrimination at work, struggles with family at home are, unfortunately, not unique to polio survivors (Longmore, 2003; Reaume, 2007; 2012; Wendall, 1996). These experiences, and their resulting silencing effect cut across disability communities and are part of the complicated shared history of disabled people. Practices of division, designation, and self-subjectification – in various spaces and places – attempted to shape the disabled body into one that was purposefully silent and subordinate.

With the high number of cases in Canada, the United States and across the globe, the response to polio was immense (Rutty, 1995). The surge of medical responses was extensive, leading to new treatments and institutions, such as rehabilitation centres focused on normalizing the body. The development of various charitable agencies, such as the Ontario Society for Crippled Children can be linked to the attempt at collecting financial resources for purposes of paying for corrective surgeries (Yoshida et al. 2013). The development of camping as both a treatment option and extracurricular activity for disabled young children started in Ontario as a direct response to polio (Yoshida, Ferguson, and Shanouda forthcoming). The majority of the responses were geared towards finding a solution – normalizing the body. The surge of institutional responses made polio unique in this respect amongst other disabilities; but these responses did not

solely affect people who had contracted polio. Medical surgeries, therapies, charities, camps, which were all developed as a means of handling the thousands of new disabled bodies from polio were available and “effective” for other disabled bodies.

Conclusion

In this paper we have explained the experiences of silence around polio that many participants spoke about in their oral life history interviews. Silence is used to describe the reality for many disabled people who are discouraged from speaking about their disability by dominant culture discourses. These discourses focused on fear, charity, and scrutiny of polio in Canada during this time (Yoshida et al. 2013). Silence is also used as a way to explain the different performances of restraint participants practiced on their bodies, including self-silencing and technologies of the self. Through our discussion of the modes of objectification - division, designation, and technologies of the self - we have demonstrated how medical, familial, and individual practices shaped the disabled polio body into one that was silent and corporative.

Participants came to resist the silencing practices that were inscribed on their bodies, changing their perspective later in life, revealing and discussing their disability. This resistance came about from a breaking of silence around their bodies – reclaiming of their bodies. Reclaiming meant acknowledging and legitimizing their felt bodily states – focusing on how their bodies felt, rather than on how others said it was supposed to feel. These brief moments of resistance constitute big shifts in thinking for our participants.

It is important to investigate historical silences amongst disabled people and within and across disability communities. We need to identify these silences and how they are propagated across marginalized communities. As shown by some of our participants, coming to the understanding that their disability is a political and cultural identity – one that is shared by others – allowed them to break the silence around polio, forming collective understandings of discrimination and a need for social change.

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